



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 31, 2026

Administrator
HERITAGE MANOR
321 NORTHEAST SIXTH STREET
CHISHOLM, MN 55719

RE: CCN: 245245

Cycle Start Date: July 31, 2026

Dear Administrator:

On July 31, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 15, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 15, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 15, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

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 \$13,343; 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 [September 15, 2026](#), the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Heritage Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from [September 15, 2026](#). 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2027 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
202-795-7490

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 at (312) 353-1502.

Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

An equal opportunity employer.



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August 31, 2026

Administrator
HERITAGE MANOR
321 NORTHEAST SIXTH STREET
CHISHOLM, MN 55719

Re: State Nursing Home Licensing Orders

Event ID: 235F35-H1

Dear Administrator:

The above facility survey was completed on July 31, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/28/2026. At the time of this survey, Heritage Manor Bldg 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:			K0000			09/04/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Heritage Manor is a 1-story building with a partial basement. The original building was constructed in 1953 and was determined to be built of Type II(111) construction. In 1981 and 2001, two additions were constructed to the building and determined to be built of Type II(111) construction. Heritage Manor is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility is divided into smoke compartments and separated from an apartment building by a two-hour fire-rated wall. The facility has a capacity of 65 beds and had a census of 60 at the time of the survey.			K0000			09/04/2026
K0223 SS = F Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area			K0223	K0223: Doors with Self-Closing Devices The double-fire barrier doors at Lake View Wing will be repaired to ensure they close properly and eliminate any gaps between compartments. All double-fire barrier doors will be inspected for proper closure and gaps and corrected if needed.		09/14/2026

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K0223 SS = F Bldg. 01	Continued from page 2 enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026, at 10:45am, it was revealed by observation that the double fire barrier doors located at the Lake View Wing, between two different smoke compartments did not close properly, leaving a gap that would allow smoke from one compartment to the other. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0223	Continued from page 2 Maintenance staff will be educated on the importance of ensuring close properly and eliminate any gaps between compartments. The Environmental Services Director/Designee will audit fire barrier doors beginning the week of 9/7/26 weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			K0353	K0353: Sprinkler System - Maintenance and Testing A quarterly sprinkler system tests will be completed quarterly per guidelines. Maintenance staff will be educated on NFPA 25 requirements for quarterly sprinkler system tests. The Environmental Services Director/Designee will audit sprinkler system tests quarterly beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0353 SS = F Bldg. 01	Continued from page 3 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026, at 09:42am, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing during the following quarters: missing third quarter (July - Sept.) and fourth quarter (Oct. - Dec.) An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0353			09/14/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and			K0712	K0712: Fire Drills Fire drills will be completed and held at varied times and conditions per requirements. ESD will develop a fire drill schedule to cover all shifts and quarters and to be held at varied times and conditions. Maintenance staff will be educated on the fire drill procedures and documentation requirements. The Environmental Services Director/Designee will audit fire drills monthly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0712 SS = F Bldg. 01	Continued from page 4 staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/28/2026, at 09:35am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 05/11/26 at 5:45PM, 08/07/26 at 5:17PM, and third shift 04/13/26 at 04:45AM, 07/22/26 at 04:00AM. 2. On 07/28/2026, at 09:35am, it was revealed by a review of available documentation that fire drills were not completed: second shift missing fourth quarter (Oct - Dec.) first shift and fourth quarter (Oct - Dec.) second shift fire drills completely. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0712			09/14/2026
K0225 SS = D Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 19.2.2.3 and section 7.2.2.2.1.1 (b) Table. Minimum width clear of all obstructions, except projections not more than 41/2 in. (114 mm) at or below handrail height on each side. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 07/28/2026, at 10:22am, it was revealed by observation that a rocking chair had been placed in the emergency exit vestibule at the bottom of the emergency stairwell exit in the shared assisted living stairwell.			K0225	K0225: Stairways and Smokeproof Enclosures The rocking chair was removed from the emergency exit at the bottom of the emergency exit stairwell. All stairways and exit enclosures will be inspected. Any obstructions found will be removed so that the emergency exit stairwells are clear. Maintenance staff will be educated on emergency exit stairwell requirements. The Environmental Services Director/Designee will audit stairways and exit enclosures, beginning 9/7/26, weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Compliance date: Sept. 14, 2026		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0225 SS = D Bldg. 01	Continued from page 5 An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0225			09/14/2026
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could have an isolated impact on the residents within the facility. The findings include: On 07/28/2026, at 10:51am, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment			K0324	K0324: Cooking Facilities ESD will install an attachment devices and alignment marks on the wheeled, gas-fired stove and griddle. ESD will review and correct any devices in the kitchen requiring alignment marks and attachment devices. Maintenance staff will be trained on proper appliance placement and required alignment marks and attachment devices. The Environmental Services Director/Designee will audit all wheeled, gas-fired kitchen appliances for alignment marks and attachments devices weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0324 SS = D Bldg. 01	Continued from page 6 device and alignment mark are required for each gas operated cooking device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324			09/14/2026
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility.			K0355	K0355: Portable Fire Extinguishers The items in front of the fire extinguisher noted during the LSC survey were removed to ensure it remains accessible. All fire extinguishers will be checked to ensure that they are accessible and not blocked. Maintenance staff will be educated on requirements to ensure fire extinguishers are accessible and not blocked. The Environmental Services Director/Designee will audit all fire extinguishers weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			K0363	K0363: Corridor Doors The resident room door latch was repaired on room 313 to ensure it latches properly. All door latches will be inspected to ensure they latch properly and corrected if found Maintenance staff will be educated on door-latching requirements. The Environmental Services Director/Designee will audit door latches weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0363 SS = D Bldg. 01	Continued from page 7 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 (1). This deficient finding could have an isolated impact on the residents within the facility. On 07/28/2026, at 10:40am, it was revealed by observation that the resident room door to room 313 does not latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363			09/14/2026
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised			K0918	K0918: Electrical Systems - Essential Electric System A reliability and fuel testing report will be documented for the generator. Maintenance staff will be educated on the generator reliability and fuel testing and documentation requirements. The Environmental Services Director/Designee will audit reliability and fuel testing documentation quarterly. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0918 SS = D Bldg. 01	Continued from page 8 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 101(2012 edition) Life Safety Code, 9.1.3.1, NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. and 8.3.8. This deficient finding could have an isolated on the residents within the facility. Findings include On 07/28/2026, at 09:23am, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability and/or a fuel testing document from a fuel company. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 8 Completion Date: 9/14/26		09/14/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g.,			K0920	K0920: Electrical Equipment - Power Cords and Extension Cords The electrical appliances plugged into power-strips, multi-plug adapters and/or extension cords in the patients room 307 were corrected and plugged directly into a wall receptacle. All areas will be inspected to ensure electrical appliances that are required per guidelines are plugged directly in to the wall receptacles. Maintenance staff will be educated on power-strips,		09/14/2026

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K0920 SS = D Bldg. 01	Continued from page 9 personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/28/2026, at 10:41am, it was revealed by observation that there were electrical appliances plugged into power-strips, multi-plug adapters and/or extension cords in the patients room 307. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920	Continued from page 9 multi-plug adapters and/or extension cords requirements. The Environmental Services Director/Designee will audit power-strips, multi-plug adapters and/or extension cords weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include			K0921	All electrically powered medical equipment will be tested per requirements with documentation. Maintenance staff will be educated on requirements of testing electrically powered medical equipment. The Environmental Services Director/Designee will audit the testing of electrically powered medical equipment annually. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

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K0921 SS = D Bldg. 01	Continued from page 10 information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supped by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/28/2026 at 10:02am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - PHASE 4: W... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/28/2026. At the time of this survey, Heritage Manor Bldg. 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Heritage Manor Bldg. 02 is a new addition completed in 2022 that includes 21 resident beds. The addition was determined to be built of Type II(111) construction. The addition is fully protected by automatic fire sprinklers and has smoke detection in the corridors, spaces open to the corridors, and resident rooms. Bldg. 02 was surveyed to the requirements of Chapter 18, New Health Care. The facility has a capacity of 65 beds and had a census of 60 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.			K0000			09/04/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
E0000	Initial Comments On 7/27 to 7/31/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			09/03/2026
F0000	INITIAL COMMENTS On 7/27 to 7/31/26, a standard recertification survey (S5245042-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. NO deficiencies were cited: H52453370C (3095651) H52453513C (1144338) H52452926C (3043780) H52453512C (1144334) H52453510C (2609673) H52453509C (2611990) The following complaints were reviewed: H52453478C (3096833) with deficiencies cited at F550 H52452897C (3041640) with deficiencies cited at F689 H52453508C (2702821) with deficiencies cited at F600, F609, F610			F0000			09/03/2026

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 reverse for further 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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F0000	Continued from page 1 H52453511C (2583675) with deficiencies cited at F895 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 substantial compliance with the regulations has been attained.			F0000			09/03/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, the facility failed to protect a resident's right to be free from mental abuse for 1 of 4 residents (R71) reviewed for abuse. This led to psychosocial harm when the resident barricaded herself into her room and caused her to discharge early from the facility prior to reaching her maximal level with therapy services. Findings include: R71's admission Minimum Data Set (MDS) dated 12/24/25, indicated R71 was cognitively intact. Diagnoses included osteoarthritis of the right hip and major depressive disorder.			F0600	F600 – Free from Abuse and Neglect – SS=G R71 and R72 no longer reside at the facility. All current residents have potential to be impacted by this deficient practice. For any resident currently demonstrating wandering, intrusive behaviors, aggression, or other behaviors that may place another resident at risk, the interdisciplinary team (IDT) reviewed the resident's current assessment, care plan, supervision needs, behavioral interventions, and staffing needs. Immediate protective interventions were implemented as indicated. Residents who may be particularly vulnerable to the behaviors of others were also reviewed to ensure appropriate protective interventions were in place. DON reviewed the Maltreatment Investigation and Reporting policy with no changes needed. Licensed nurses, nursing assistants, social services, and administrative staff were educated by the DON/designee on the Maltreatment Investigation and Reporting policy, including recognition of resident-to-resident abuse, immediate protection of residents, notification of administration, implementation of effective interventions, reassessment when interventions are ineffective, and the responsibility to provide adequate supervision. When a resident demonstrates behaviors that may endanger or cause psychosocial harm to another resident, the IDT will evaluate the effectiveness of interventions and implement additional interventions as necessary, including increased supervision, environmental modification, room changes when		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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F0600 SS = G	Continued from page 2 R71's Census List dated 7/30/26, indicated R71 was admitted on 12/18/25 and discharged from facility on 12/30/25. R71 remained in the same room throughout their stay. R71's care plan dated 12/24/25, indicated R71 was a vulnerable adult related to physical condition. Goals included the resident would be free from abuse, neglect, or financial exploitation. The care plan lacked interventions to protect from abuse. A Minnesota Adult Abuse Reporting Center (MAARC) report received 12/29/25 at 1:28 p.m., indicated R72 hit R71's bed at 1:00 a.m., and woke R71 up. R71 told R72 to leave. R72 grabbed a blanket off a chair and walked out. The MAARC report indicated R72 had entered R71's room without permission and had scared R71. The MAARC report further indicated a risk of physical abuse or sexual assault within 72 hours if nobody got involved. Further notes indicated on the night of 12/29/25, R72 attempted to enter R71's room. "An alarm of sorts" had been set up at the entrance to the room. A walker was used in the doorway to barricade R72 from getting in. R72 just pushed the walker out of the way and entered R71's room anyway and then left shortly after entering. R71's progress notes from 12/25/25 to 12/30/25, were reviewed and showed the following: On 12/27/25 at 2:28 p.m., Licensed practical nurse (LPN)-A wrote R71 approached nurse and reported R72 was in her room multiple times the night before and scared R71. R71 stated R72 had grabbed some belongings and left the room. R71 requested staff to call her lawyer. Director of Nursing (DON) was notified of the situation and provided with information to contact R71's lawyer. A "stop" sign banner was placed across R71's door. On 12/29/25 at 11:43 a.m., licensed social worker (LSW)-C wrote R71 requesting to be discharged (DC) from the facility on 12/30/25, after a 10:00a.m., appointment. The plan was not to return to the facility. On 12/29/25 at 2:22 p.m., LSW-C wrote a conversation occurred between SSD-A and R71 about a "wanderer" who entered her room. R71 had a stop sign in place across the door and was closing the room door. On 12/30/25 at 1:00 a.m., LPN-C wrote R71on two different nights in a row placed a walker in front of			F0600	Continued from page 2 appropriate, behavioral-health/provider consultation, staffing adjustments, and transfer/discharge when the facility cannot safely meet the resident's needs. The DON/designee will audit residents identified with behaviors that pose a risk to others and associated resident-to-resident incidents weekly for 4 weeks, then monthly for 2 months starting the week of 9/7/26. Audits will verify that identified residents are protected, interventions are individualized and effective, care plans are current, and staffing/supervision is sufficient. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0600 SS = G	Continued from page 3 the door to barricade R72 from entering room. R71 stated “I’m scared to death of him”. R71 had put the call light on at the beginning of the shift to report R72 had already attempted to enter R71’s room. Staff informed R71 They could only redirect when they were able. R71 reported leaving in the morning. On 12/30/25 at 10:33 a.m., LSW-C wrote R71 DC’d from facility to return to home. R71’s Occupational Therapy Treatment Encounter Note dated 12/29/25, indicated R71 had improvement, but needed more high-level therapy prior to DC from the facility. R71 told therapy staff she was leaving tomorrow after her appointment because she couldn’t be here anymore because of my neighbor coming into my room. R72’s admission MDS dated 12/9/25, indicated R72 had moderate cognitive impairment. Diagnoses included vascular dementia with agitation and Alzheimer’s disease. The MDS indicated R72 paced and wandered daily and significantly disrupted the care or living environment of other residents. R72’s Census List dated 7/30/26, indicated R72 was moved to another room on 12/19/25 that was near R71, and remained there until 4/15/26, when the next room change occurred. R72’s Care plan dated 12/3/25, indicated R72 had behaviors like restlessness, agitation, sundowning, difficulty sleeping, wandering into other resident rooms and urinating in public. Goals included R72 would have no evidence of behavior problems by next review date. Interventions included medications, redirect me, one to one(1:1) time, and update provider with concerns. R72’s progress notes from 12/25/25 to 12/30/25, were reviewed and indicated: On 12/26/25 at 4:09 p.m.,--R72 became agitated after family left. R72 began wandering into other resident rooms and became angry when staff attempted to redirect. R72 was cursing and attempted to become physically aggressive with staff. R72 entered a resident room and shook a fist at the resident’s family member. Staff had difficulty removing R72 from room and “punched” resident door while being removed. On 12/27/26 at 8:26 p.m., R72 wandered into other resident rooms throughout building. Difficult to redirect and easily agitated. Residents and family			F0600			09/14/2026

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F0600 SS = G	Continued from page 4 members became upset with R72 entering other resident rooms and how difficult it is to remove R72 from those rooms. Resident placed on 1:1 supervision with nurse assistant. (the note did not state how long R72 remained on 1:1) On 12/28/25 at 2:03 p.m., R72 was at dining hall and started yelling “NO, NO, NO”. R72 picked up the fork and clothing protector, began walking around the park area with fork grabbed in hand and swinging clothing protector to hit things. R72 then requested to use the restroom so staff started to assist R72 to restroom. R72 then grabbed the staff member's hand and dug his nails in, breaking skin. R72 then went into a different resident room and urinated. R72 then grabbed a different resident wheelchair (WC) and started pulling the WC backwards. Lastly R72 took another resident's crossword puzzle from that resident and smashed it up and threw it. It took three different staff to redirect R72. On 12/28/25 at 5:20 p.m., R72 was witnessed taking a necklace and phone charger from a resident. When the staff member tried to check R72's pockets, R72 punched the staff member in the upper arm leaving a large red area. On 12/29/25 at 6:45 a.m., R72 was extremely agitated the end of evening shift into night shift. R72 was yelling, swearing, attempting to open office doors, pounding on doors, raising his fist to staff, turning over furniture, pounding the recliner remote on the over bed table and entering other resident rooms. R72 was unable to be redirected and became more agitated and angrier when staff attempted. On 12/30/25 at 1:22 a.m., R72 required 1:1 monitoring due to wandering into other resident rooms and other units of the building. Behaviors are not redirectable. Unable to keep R71 in one place at this time. (Note does not state how long R72 was on 1:1). On 12/30/25 at 2:49 a.m., R72 walked quickly and “within a minute” of nursing checking on another hallway, R72 was unable to be found in the previous area last seen. Staff had to check room by room to locate R72. During an interview on 7/29/26 at 10:26 a.m., nurse assistant (NA)-B stated R72 was very confused and would escalate behaviors very quickly. Just talking to him would cause him to get more aggressive. He was always wandering into other resident rooms. Sometimes he would even take other resident items			F0600			09/14/2026

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F0600 SS = G	Continued from page 5 while in their rooms. Staff would go in to redirect him, and he would just become more aggressive with the staff and get madder. A lot of times it would take two or more staff to get him out of another resident room. The facility attempted stop sign banner across a lot of the residents' doors. The stop sign banners would never stop him. Even closed doors didn't stop him, if R72 wanted to go into a room he would move whatever was in his way and go in. Nobody had ever mentioned there were concerns directly related to R71 and R72. The administration staff wanted us to attempt 1:1 with R72 but we hardly had enough staff to care for all the residents in the facility, let alone assign a person just to work with him. The worst was on night shift where we normally only had two aides and one nurse to take care of the entire building. Staff were always going to the director of nursing (DON) asking more staff to keep a closer eye on R72 but nothing ever came out of it. Most of the residents were afraid of R72. During an interview on 7/29/26 at 11:27 a.m., licensed practical nurse (LPN)-A stated R71 came to her on the morning of 12/27/25, and reported R72 had come into the room several times the night before. When R71 told R72 to leave the room, R72 snarled at R71, grabbed R71's blanket, and then left the room. LPN-A stated R71 told her R71 was very scared of R72. The DON was notified of the resident-on-resident altercation. The DON said to put a stop sign banner across R71's door. LPN-A stated I reminded the DON the stop sign had not worked on R72 so far and was there any other measures to try. The DON stated to just keep an eye on R72. Several times throughout the week of Christmas we requested extra staff to do 1:1 observation with R72 and we were told by the DON the facility did not offer 1:1 care service. The staff were expected to do 1:1 service, when possible, when we never had enough staff to get everything done, we needed to get done routinely each day. Because of this, R72 was, for the most part, able to roam around the facility and enter other residents and we attempted to address after it happened and before somebody got hurt. During an interview on 7/29/26 at 11:00 a.m. LSW-C stated she had gone into R71's room because a staff member said she wanted to go home due to the issues related to R72 always going into R71's room. R71 requested to be discharged from the facility on the a.m. of 12/30/25, because her sister would be there to take her to an appointment and had no plan on returning to the facility.			F0600			09/14/2026

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F0600 SS = G	Continued from page 6 During an interview on 7/29/25 at 11:27 a.m., registered nurse (RN)-E stated anytime there were concerns of abuse or resident on resident incidents they would be reported to the administration. All notes made the last 24 hours, and any abuse concerns would then be brought up and discussed in the Inter-Disciplinary Team (IDT). RN-E stated she was part of the IDT team. The team would discuss the concerns related to any abuse or resident on resident altercations and what needed to be done to protect the residents. RN-E reviewed R71's progress notes and acknowledged the notes from 12/27/25 to 12/30/25. RN-E stated an inability to remember if the notes were discussed in IDT, but assumed they were since all notes from the last 24 hours entered into resident notes would have been reviewed and anything concerning, such as those notes, would have been brought to the IDT meeting to discuss. RN-E also could not remember if there was anything done to protect R71 from R72 since the notes did discuss R71 was very scared of R72. The IDT notes from the IDT meetings on 12/26/25 through 12/30/25 were requested but not provided. During an interview on 7/29/26 at 11:39 a.m., the DON stated on 12/26/25, she was not the DON at the time of the allegations, but the evening charge nurse. She had been made aware of the situation but was unsure what all the administration team or IDT team had discussed. The DON stated she was aware the stop sign was placed but did not believe anything else was done to protect R71 from R72. The DON reviewed R71's progress notes and acknowledge concerns arose even after the "stop" sign banner was placed across the doorway. During an interview on 7/30/26 at 9:40 a.m., the administrator stated the resident had a "stop" sign banner placed across her door. Staff was doing 1:1 with the resident, The facility even brought in extra staff just to be able to work 1:1 with R72. I'm not sure what else we could have done to protect any resident. On 7/30/26 at 10:00 a.m., the facility assessment (FA) dated 6/1/26, was reviewed and indicated a staffing plan with the following number of licensed nurses were needed to staff the facility: Days-3, Evenings-3, Nights-1. The FA indicated the following number of NA's were needed to staff the facility: Days-5/6, Evenings-5/6, Nights-3. The daily staff assignment sheets for 12/26/25 through 12/30/25 were reviewed for all shifts and indicated the following staff numbers:			F0600			09/14/2026

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F0600 SS = G	Continued from page 7 12/26/25: Days-4 nurses and 4.5 NA, Evenings - 4 nurses and 6 NA, Nights- 1 nurse and 3 NA 12/27/25: Days-3 nurses and 4 NA, Evenings - 3 nurses and 6 NA, Nights- 1 nurse and 3 NA. 12/28/25: Days-4 nurses and 4 NA, Evenings - 3 nurses and 6 NA, Nights- 1nurse and 2 NA. 12/29/25: Days-3 nurses and 6 NA, Evenings - 4 nurses and 4 NA, nights- 1 nurse and 2 NA. 12/30/25: Days-3 nurses and 6 NA, Evenings - 4 nurses and 4.5 NA, nights- 1 nurse and 2 NA. The assignment sheets from 12/26/25 to 12/30/25, lacked a staff member responsible for 1:1 observation with R72 or that any extra staff were brought in to work any shift. Many shifts indicated short staffing for either nurses or aides for several shifts, based on the staffing plan in the FA.In an email received from the DON on 7/30/26 at 12:00 p.m., the email indicated room change would not have been offered because the facility wanted trial the stop signs. Room change was rarely offered on first "complaints". During an interview on 7/30/26 at 12:09 p.m., the therapy director (TD) reviewed all R71's therapy notes from 12/26/25 to 12/30/25, and stated the notes clearly indicated R71 was improving on a daily basis but still needed to work on high level activities of daily living prior to therapy agreeing with a discharge back to home. The TD stated based on the occupational therapy notes from 12/29/25, it was clear R71 was requesting a discharge to home prior to reaching maximum levels was because of another resident continually trying/coming into R71's room. During an interview on 7/30/26 at 2:01 p.m., LPN-C stated she worked night shift in the facility and had worked the night of 12/28/25 and 12/29/25. R72 was very difficult to handle, especially on night shift. For whatever reason, R72 liked going in/trying to go into R71's room, I assume it was because they were next to each other. On the first night R71 tried to block R72 from coming into her room by utilizing the walker, and putting it behind the closed door as a barricade. R71 would just push the door and walker out of the way and go in. we would have to rush over and redirect R72 out of R71's room, but he would keep roaming and wandering into other rooms. After that occurrence on the night of 12/28/25, and on the night of 12/29/25, R71 began utilizing her closet door, bedside table, and walker			F0600			09/14/2026

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F0600 SS = G	Continued from page 8 together as a barricade against the closed door to keep R72 from coming in. Those steps did not keep R72 from trying to go into R71's room and pounding on R71's room door. you could tell R71 was really afraid of R72 due to all the steps R71 took to keep R72 out of her room. Both mornings we had to have R71 move items from her door so staff could get in and issue early morning medications. During an interview on 7/31/26 at 9:48 a.m., the scheduler (SC)-A confirmed the numbers on the facility assessment were the numbers the facility tried to staff daily. nurses would be written in the nursing columns and aides would be written in the NA column. If a name had a circle around it, that meant the person called in. if there was a dollar sign next to the name, that meant the staff member received a bonus for working extra. The facility did not offer bonuses of try to call people in unless the numbers were really low. For example, if a night shift only had one aide working and one nurse then they would call to try to get extra aides to work. If there were two aides working the facility would say that was ok unless the census was high. SC-A stated she could not remember if extra staff were requested in around Christmas, even if they were it would have been almost impossible to get because of being short of staff at that time. We couldn't get our own staff or agency staff to pick up shifts around the end of December, so the facility was lucky if we had enough staff to cover the normal shifts. Facility policy Maltreatment Investigation and Reporting dated 3/10/26, indicated when physical, sexual, or mental abuse is reported the supervisor must promptly secure the resident's safety and complete an initial assessment. Immediate interventions must be put in place to safeguard the resident(s) and prevent further harm. An initial report would be made to the SA. That report would a description of the event, immediate interventions taken to protect the resident and the status of the alleged perpetrator. after the immediate protection was in place, the incident would be reviewed by the IDT. The review would evaluate the effectiveness of interventions and determine the need for corrective or preventive actions. Any operational or systemic changes and training needed to prevent recurrence would be implemented based on investigative findings.			F0600			09/14/2026
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)			F0550	F550 – Resident Rights/Exercise of Rights – SS=E The facility replaced outdated copies of the		09/14/2026

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F0550 SS = E	Continued from page 9 §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. §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 observation, interview and record review, the facility failed to ensure residents were provided with the current Combined Federal and State Bill of Rights. This had the potential to affect all 62 residents and their representatives who resided in the facility. Findings include:			F0550	Continued from page 9 Combined Federal and State Bill of Rights with the current version in admission materials and other locations where resident-rights information is provided. All current residents have the potential to be impacted by this deficient practice. Current residents and/or representatives were provided access to the current Federal and State Bill of Rights by the Admissions Coordinator/designee. Admission materials were reviewed to ensure outdated versions were removed. Admissions and Social Services staff who are responsible for providing resident-rights information were educated by the Administrator/designee regarding use of the current Bill of Rights and the requirement to provide residents and representatives with information regarding their rights. A process was established for designated staff to verify that admission materials remain current when regulatory or organizational forms are revised. The Administrator/designee will audit 5 admissions or all admissions if fewer than 5 weekly for 4 weeks and monthly for 2 months to verify residents/representatives receive the current Bill of Rights beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0550 SS = E	Continued from page 10 In response to a concern reported in 2026, R26 felt their rights had been violated when they resided in the facility for six days. A review of the facility's admission folder identified they were providing residents with the Combined Federal and State Bill of Rights dated 2/1/17. The most current Federal and State Bill of Rights has a date of 12/22/25. During an interview on 7/30/26 at 12:03 p.m., the director of nursing (DON) stated they did not know how residents received their admission packet. During an interview on 7/30/26 at 12:22 p.m., registered nurse (RN)-I stated residents can receive their admission packet in paper form or electronically.			F0550			09/14/2026
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			F0657	F657 – Care Plan Timing and Revision – SS=E R48 and R5 no longer reside at the facility. The care plans for R25 and R3 were reviewed and revised, as applicable, to accurately reflect current care needs across the interdepartmental team. All current residents have the potential to be impacted by this deficient practice. Current resident care plans were reviewed by the DON/designee for discrepancies between the most recent MDS/assessment, therapy recommendations, physician orders, IDT discussion, and progress notes. Identified discrepancies were corrected. DON reviewed the Person Centered Care Planning policy with no changes needed. All staff who update resident care plans were educated by the DON/designee on the Person Centered Care Planning policy regarding timely review and revision of the comprehensive care plan following assessments and changes in condition, function, preferences, treatment, or services. The facility reviewed and revised the communication process requiring changes identified by therapy or other disciplines to be communicated to nursing and incorporated into the comprehensive care plan/care guide when applicable. The DON/MDS Coordinator/designee will audit 3 current resident comprehensive care plans weekly		09/14/2026

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F0657 SS = E	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to review and revise the care plan to reflect the resident's current needs for 4 of 4 residents (R25, R48, R3, R5) reviewed for care planning. Findings include: R25: R25's quarterly minimum data set (MDS) dated 7/7/26, identified severely impaired cognition and diagnoses of diabetes mellitus, malignant neoplasm of the lung, and secondary malignant neoplasm of the bone. R25 needed set-up assistance for eating, maximum assistance with toilet hygiene, and dressing the lower body. The MDS also indicated R25 was occasionally incontinent of urine and always incontinent of bowel. R25's care plan dated 6/12/25 identified a focus statement for activities of daily living (ADL)s self-care performance deficit and included interventions for partial to moderate assist with showers, R25 able to complete upper, lower body and footwear independently, and was independent with eating, personal hygiene and oral care. R25 needed to be offered to bring to the toilet every two hours and as needed due to bladder incontinence. The care plan further identified R25 was alert and oriented to person, place, and time with intermittent confusion. BIMS (cognitive score) indicated moderate cognitive impairment. During an interview on 7/30/26 at 11:24 a.m., registered nurse (RN)-H, who identified as the MDS coordinator, stated there wasn't enough change in R25's quarterly MDS (compared with a significant change MDS of 4/9/26) from her baseline to be a significant change again. RN-H stated care planning was done by the nurses when they did the assessments, they will update the care plan and RN-H added once she was fully running, she would be updating the care plans. During an interview on 7/30/26 at 11:52 a.m., RN-E, who identified as the charge nurse, stated she was given a list of what assessments were due and when, and then she along with the other charge nurses would update the care plan. RN-E stated an up-to-date care plan would be important to be able to care for the residents safely and properly.			F0657	Continued from page 11 for 4 weeks and monthly for 2 months beginning the week of 9/7/26 to compare current assessments, orders, therapy recommendations, resident preferences, and care plans. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0657 SS = E	Continued from page 12 R48: R48's quarterly MDS dated 6/24/26, identified intact cognition and diagnoses of encephalopathy, aphasia, spondylosis of the thoracic, lumbar and cervical regions. R48 was independent with eating and needed set-up oral care. R48 needed maximum assist with showers, personal and toilet hygiene, transfers, and bed mobility, and was dependent for toilet hygiene with occasional bowel incontinence. R48's care plan dated 3/27/26, identified a focus statement for an ADL self-care performance deficit and included interventions for total dependence and assist of two staff for bathing, transferring with non-mechanical standing lift and assist of two staff and if he was unable to stand with that then use the mechanical sling lift. R48's care plan also included a focus statement for requiring g-tube feedings due to dysphagia (difficulty swallowing) with interventions to administer feedings as ordered but may have ice chips with supervision. R48 had bowel incontinence related to immobility and interventions for staff to check every two hours and assist with toilet and provide peri care PRN. R48's therapy orders included a memo on the inside of his closet door dated 7/23/26, for R48 to use a stand pivot transfer using a gait belt and contact guard assist of one. During an interview on 7/27/26 at 5:10 p.m., R48 was eating his dinner in his room and stated he didn't use his feeding tube anymore, just for one of his medications. During an interview on 7/28/26 at 3:23 p.m., nursing assistant (NA)-D stated she knew how to transfer R48 because of the posting from therapy in his closet. NA-D also stated R48 used the toilet, not a bed pan as the care plan indicated. During an interview on 7/28/26 at 3:27 p.m., RN-E, who identified as a charge nurse, stated if something needed to be updated to the care plan she would just do it but thinks the MDS nurse also has a part in it. During an interview on 7/29/26 at 1:56 p.m., the therapy director (TD)-I stated once they established the plan of care through evaluation, they write a care plan for transfer and level of assist, or walking program or whatever applied. TD-I stated they then put that care plan in the resident's room in their cabinet door and gave a copy to the director of nursing (DON) and nurse managers, and on a weekly			F0657			09/14/2026

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F0657 SS = E	Continued from page 13 basis he presents a weekly update to DON, MDS coordinator, nurse managers and department heads. A policy, Person Centered Care Planning dated 6/16/26, identified its purpose was to provide guidance to care center staff on developing and establishing the resident's person-centered care plan. Person-centered care planning identifies each resident's individualized strengths, needs, preferences, supports, and goals to guide care and services. Care plans must include measurable goals and timeframes based on the comprehensive assessment. If the comprehensive assessment identifies changes in goals, interventions, or functioning that were not identified in the baseline care plan, those changes will be communicated to the resident and/or representative, with an updated care plan provided. The comprehensive care plan will be reviewed and revised quarterly, upon significant change in condition, or as otherwise necessary to reflect the resident's current needs, goals, and preferences. R3: R3's quarterly Minimum Data Set (MDS) dated 6/29/26, identified R3 had diagnoses which included hemiplegia/hemiparesis (complete or severe paralysis on one side of the body/mild to moderate weakness on one side of the body), dysphagia (difficulty or discomfort when swallowing foods, liquids, or even saliva), hyperlipidemia, aphasia (a brain disorder that affects how one speaks, reads, writes, and understanding what other people say), hypertension. In addition, R3's MDS identified she had unclear speech, was severely cognitively impaired, and was dependent on staff for activities of daily living. R3's care plan reviewed on 7/28/26, (care plan was requested but not provided) did not identify that R3 did not want male care givers. R3's progress note dated 3/8/26, identified no males for personal cares. During an interview on 7/29/26 at 1:42 p.m., nursing assistant (NA)-G stated it was only "word of mouth" that R3 only wanted female care givers for personal cares. NA-G verified there was nothing on the care guides to indicate she only wanted female care givers. During an interview on 7/29/26 at 1:44 p.m., licensed practical nurse (LPN)-A verified the care plan did not identify R3 preferred only female care			F0657			09/14/2026

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F0657 SS = E	Continued from page 14 givers. During an interview on 7/30/26 at 12:29 p.m., the director of nursing (DON) stated she was aware R3 did not want any male care givers. The DON verified this information should have been part of her care plan. R5: R5's admission MDS dated 5/13/25, identified she had diagnoses which included dementia, heart failure (the heart muscle does not pump blood as well as it should), diabetes mellitus, depression, hyperlipidemia, and heart disease. In addition, R5's MDS identified she was moderately cognitively intact, required supervision with eating and partial to moderate assistance with activities of daily living. A review of R5's care plan on 7/28/26, identified R5's care plan did not identify she needed to be out of bed for meals. A progress note dated 7/6/26 written at 1:59 p.m., identified therapy reported increased confusion and weakness when sitting at the bedside. The note identified she was unable to hold herself up. The note identified she was also spilling food when eating in bed. Therapy recommended they would like her to be up in her chair for meals. During an observation on 7/28/26 at 12:10 p.m., R5 was observed lying in her bed eating her lunch. During an observation on 7/29/26 at 8:37 a.m., R5 was observed lying in bed eating breakfast. During an interview on 7/29/26 at 1:39 p.m., nursing assistant (NA)-G and licensed practical nurse (LPN)-A both stated they were not aware R5 was supposed to be out of bed for meals. They were unsure how therapy communicated the information for R5 to be in her chair for meals. LPN-A verified the information was in the progress notes but the care plan had not been updated with the information. During an interview on 7/30/26 at 10:52 a.m., therapy director (PTA)-A stated staff in the therapy department would write a care plan for the resident to identify the resident needed to be up for meals, that information would go to the nurse manager and the DON and then the information would get put into the resident's closet. PTA-A reviewed the notes and identified nursing had been informed of the change but that a care plan change had not been made. PTA-A stated therapy would be responsible for			F0657			09/14/2026

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F0657 SS = E	Continued from page 15 making the changes and posting the changes in the closet. During an interview on 7/30/26 at 12:14 p.m., the DON stated she would expect nursing to get R5 up for meals per therapy's recommendation and make this part of her care plan. She would expect staff to continue to evaluate R5's care and update the care plan as needed. Person Centered Care Planning dated 4/20/23, identified the facility would develop a comprehensive person-centered care plan with the resident and/or family representative for each resident. In addition, the care plan would be reviewed every 90 days or more frequently if necessary, based on changes that occurred between care conferences.			F0657			09/14/2026
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.			F0883	F883 – Influenza and Pneumococcal Immunizations – SS=E R14 and R48 no longer reside at the facility. The immunization records of R54 were reviewed. R54 was provided appropriate education and offered indicated influenza and pneumococcal vaccination consistent with current recommendations, unless contraindicated or previously administered. Acceptance, refusal, contraindication, education, and administration were documented as applicable. All residents have the potential to be impacted by this deficient practice. The Infection Preventionist/designee reviewed current resident influenza and pneumococcal vaccination records to identify residents lacking evidence of vaccination, appropriate offering, education, refusal, contraindication, or required follow-up. DON/designee reviewed the Resident Immunizations policy with no changes needed. Licensed nurses and appropriate staff were educated by DON/designee on the Resident Immunization policy, regarding the facility immunization process, including review of vaccination history, education, offering indicated vaccines, obtaining/documenting consent or refusal, and documenting administration in the EMR and applicable immunization registry. The Infection Preventionist/designee will audit 3 resident immunization records weekly for 4 weeks and monthly for 2 months beginning the week of 9/7/26. Results will be reported to QAPI for review		09/14/2026

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F0883 SS = E	Continued from page 16 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to consistently educate, offer, or administer influenza and pneumococcal immunizations for 3 of 5 residents (R14, R48, R54) reviewed for immunizations. Findings include: R14's Admission Record dated 7/31/26, identified an admission date of 3/4/26. R14's undated and unsigned Vaccination Consent didn't identify if R14 had previously had an influenza or pneumococcal vaccination or if R14 wanted, or was eligible for, these vaccinations. In the area where a resident or representative could sign, or the facility could document phone notification, it was written "No!" signed health unit coordinator (HUC)-G. R14's electronic medical record (EMR) identified R14 had received Prevnar 13 on 12/15/15, and influenza vaccine on 12/3/25. According to the CDC, R14 was			F0883	Continued from page 16 and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0883 SS = E	Continued from page 17 eligible for shared decision making with their provider to decide if PCV20 or PCV21 should be administered as it was more than one year since the Prevnar 13 dose. R54's record didn't include evidence of shared decision making or receipt of additional pneumococcal vaccination. R48's Admission Record dated 7/31/26, identified an admission date of 3/26/26. R48's Vaccination Consent dated 5/7/26, didn't identify R48 had history of receiving the influenza vaccine and identified "no" to receiving it now. Under pneumococcal vaccination, it identified "no" to having received prior vaccinations and "no" to receiving it now. The Consent contains the following: "Enclosed is the vaccine information sheet from the Centers for Disease Control (CDC) that addresses the potential benefits, precautions, side effects, and reactions. I have read the vaccine information from the CDC and understand the benefits and risks associated with receiving the vaccine", with a signature line for the resident or representative which was not signed. A section for resident representative notification via telephone identified HUC-G notified R48's spouse via telephone and spouse declined all immunizations. R48's Immunization Report dated 7/31/26, identified R48 had received PPSV23 on 11/19/14 and Prevnar 13 on 12/16/15. According to the CDC, R48 was eligible for shared decision making with their provider to decide if PCV20 or PCV21 should be administered as it was more than five years since the Prevnar 13 dose. R54's Admission Record dated 7/31/26, identified an admission date of 8/8/25. R54's Vaccination Consent dated 4/15/26, identified R54 had received pneumococcal vaccines and would like to receive it. The form also indicated a vaccine information sheet (VIS) was given to R54 on 5/29/26 and was signed by R54's power of attorney on 4/15/26. R54's record in PCC identified receiving Prevnar 13 on 11/8/16, and PPSV23 on 11/22/19. According to the CDC, R54 was eligible for shared decision making with their provider to decide if PCV20 or PCV21 should be administered as it was more than five years since the PPSV23 dose. R54's record didn't shared decision making or receipt of vaccination. During an interview on 7/29/26 at 1:20 p.m.,			F0883			09/14/2026

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F0883 SS = E	Continued from page 18 registered nurse (RN)-G, who identified as the Infection Prevention and Control nurse for the facility, was responsible for pulling the resident's Minnesota Immunization Information Connection (MIIC) report and uploaded it to Point Click Care (PCC, an electronic health record) and then entered the immunizations into the immunization section of PCC when new residents were admitted. RN-G stated they were the only person who did the vaccine review and she utilized the CDC pneumorec application to see what pneumococcal vaccines the resident may be eligible for. RN-G added two of these admissions were during a period of time where she was needing to serve as the facility's director of nursing and there were things that were behind. A policy, Resident Immunizations dated 1/21/25, identified the purpose was to provide direction to St. Francis Health Services of Morris (SFHS) employees regarding offering vaccinations. Additionally, the Adult Immunization Schedule, prepared by the CDC would be utilized to ensure residents were offered and encouraged to accept the appropriate vaccination. The policy also identified an immunization history will be taken upon admission. This will include checking the Minnesota Immunization information Connection (MIIC) website. Any immunizations that are not current or unknown vaccination histories will be shared with the attending physician and appropriate physician orders obtained. The resident's immunization history will be documented and maintained in the resident's electronic medical record (EMR). Vaccine Information Statements (VIS) will be provided to the resident and/or representative prior to administration of the vaccination. Education will be provided, and any questions answered, prior to administration of the vaccination. resident representative identified in the record. Administered immunizations will be documented in the EMR and on the MIIC website. Record that the resident or representative was provided education regarding the benefits and side effects of the immunization administered		F0883			09/14/2026	
F0895 SS = E	Compliance and Ethics Program CFR(s): 483.85(a)-(e) 483.85 Compliance and ethics program. §483.85(a) Definitions. For purposes of this section, the following definitions apply: Compliance and ethics program means, with respect		F0895	F895 – Compliance and Ethics Program – SS=E The records identified for R31, R39, R40, and R61 were reviewed for MDS and diagnosis integrity. Unsupported diagnoses and inaccurate documentation were corrected as appropriate, and affected assessments were modified in accordance with applicable requirements.		09/14/2026	

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F0895 SS = E	Continued from page 19 to a facility, a program of the operating organization that- §483.85(a)(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and §483.85(a)(2) Includes, at a minimum, the required components specified in paragraph (c) of this section. High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization. Operating organization means the individual(s) or entity that operates a facility. §483.85(b) General rule. Beginning November 28, 2019, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section. §483.85(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components: §483.85(c)(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act. and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals	F0895	Continued from page 19 The facility's compliance reporting policy and process was reviewed to ensure staff have a mechanism to report suspected violations, including concerns involving high-level personnel, without fear of retaliation with no changes needed. A review was conducted of residents potentially affected by the identified MDS/documentation irregularities to determine whether unsupported diagnoses, signature irregularities, or other documentation discrepancies were present. Identified concerns were investigated and corrected as appropriate. MDS staff, nursing leadership, administration, and other applicable staff were educated regarding the corporate compliance policy including documentation integrity, accurate MDS reporting, prohibition against falsification, and the process for reporting compliance concerns. The MDS Coordinator/designee will conduct audits of MDS documentation and supporting diagnoses for 5 residents weekly for 4 weeks and monthly for 2 months beginning the week of 9/7/26. Compliance reports and concerns will also be reviewed to verify appropriate investigation, escalation, and protection against retaliation. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26	09/14/2026

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F0895 SS = E	Continued from page 20 providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. §483.85(c)(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization. §483.85(c)(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures. §483.85(c)(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act. §483.85(c)(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at §483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program. §483.85(c)(6) The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within			F0895			09/14/2026

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F0895 SS = E	Continued from page 21 the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data. §483.85(c)(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program. §483.85(c)(8) After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act. §483.85(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program: §483.85(d)(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in §483.95(f). §483.85(d)(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer. §483.85(d)(3) Designated compliance liaisons located at each of the operating organization's facilities. §483.85(e) Annual review.			F0895			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0895 SS = E	Continued from page 22 The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement an effective compliance and ethics program with sufficient monitoring and auditing mechanisms to detect and prevent potential violations and ensure the integrity of the data reported to the Centers for Medicare and Medicaid services (CMS). The facility further failed to ensure employees could report, without fear of retaliation, a high-level personnel's suspected violations. These failures resulted in documentation and minimum data set (MDS) irregularities with unsupported or inconsistently reported diagnosis for 4 of 4 residents (R31, R39, R40, R61) reviewed. Findings include: R31's Admission Record identified an admission date of 1/25/23. R31's quarterly minimum data set (MDS) dated 11/5/25, didn't contain diagnosis code F33.3 (Major Depressive Disorder Severe with Psychotic Symptoms) in section I. On 12/16/25, RN-A modified the 11/5/25 MDS to include diagnosis F33.3 under section I. R31's Diagnosis Audit Report identified F33.3 was added to his EMR on 1/15/25 with an effective date of 1/25/25. A progress note from R31's provider on 4/21/26, included a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did contain a diagnosis for severe Lewy body dementia with agitation, depressive disorder in remission noting resident "can be very happy when alert". R31's progress notes didn't reflect supporting documentation for the F33.3 diagnosis that was added to his medical records. A provider order for R31's F33.3 diagnosis was requested but not received.			F0895			09/14/2026

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F0895 SS = E	Continued from page 23 R39’s significant change in status assessment (SCSA) MDS dated 10/18/23, completed by RN-A included diagnosis F33.3. R39’s history and physical dated 8/13/23, identified diagnoses of late onset Alzheimer’s disease without behavioral disturbance and generalized anxiety disorder, but didn’t contain diagnosis F33.3. R39’s Diagnosis Audit Report identified F33.3 was added to her record on 1/15/25 with an effective date of 8/17/23. A provider order for diagnosis F33.3 was requested but not received. R61’s SCSA MDS dated 10/16/25, didn’t identify a diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified a diagnosis code of F33.3. An additional modification was made on 4/13/26 by RN-B, and section I no longer included diagnosis code F33.3. R61’s Order Summary Report dated 11/25/25, didn’t include a diagnosis for F33.3. A diagnosis audit report dated 7/31/26, identified R61 had diagnosis F33.3 added to her EMR by RN-A on 12/16/25 at 10:36 a.m. as an effective diagnosis beginning on 1/22/25. A document, Physician Update facsimile for R61, from the facility to the provider was timestamped and dated 6/23/25 10:59:10, identified a request for diclofenac gel for low back pain with dosing directions with a “yes or no” and the “yes” is circled, signed by medical doctor (MD)-K on 6/24/25. The facsimile from the clinic was timestamped and dated 6/24/26 10:38:17. A document, Physician Update facsimile for R61, from the facility to the provider was timestamped and dated 6/23/25 10:59:10, identified the following, “OK to use diagnosis F33.3 Major Depressive Disorder Severe with Psychotic Symptoms?” with a “yes or no” and the “yes” is circled, signed MD-K on 6/24/25. The facsimile from the clinic was timestamped and dated 6/24/26 10:38:17. During an interview on 7/30/26 at 9:09 a.m., RN-C stated after their case mix review the summer of 2025, she had a lot of corrections to make and as she was doing those, she noticed a couple of MDS’			F0895			09/14/2026

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F0895 SS = E	Continued from page 24 where it looked like she had done modifications that she didn't remember doing. RN-C investigated the audit trail histories of the MDS, and it would show that her supervisor, RN-A who was the director of nursing (DON), and two corporate nurses were making the modification. Some would be things like adding a Medicare number. RN-C stated she didn't want to report internally because it was her supervisor, and RN-C had been put on a performance improvement plan (PIP) related to the citations coming out of the case mix review and she was fearful of retaliation. Between 7/24/25 and 8/5/25, RN-C filed concerns with CMS, the Office of Health Facility Complaints (OHFC), the Minnesota Board of Nursing and the Office of the Inspector General (OIG). RN-C stated that on 2/2/26 she found a fax from June of 2026 for R61 which had a new diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms and the fax appeared to have been modified. RN-C stated she took a side-by-side photo of the two orders, and the fax time was identical down to the millisecond. RN-C stated that it appeared that a faxed order for diclofenac gel (topical medication to reduce pain and inflammation) for R61 was photocopied, and the body of the message cleared and this different order for a diagnosis, major depressive disorder severe with psychotic symptoms (diagnostic code F33.3) was in its place. RN-C e-mailed a corporate nurse (CN)-O on 2/2/26 about her concerns with R61 and R72's MDS modifications and suspicion regarding documentation. RN-C stated the facility administrator came to her that day to talk about her concerns for diagnosis changes without supporting documentation and asked for an example which she provided. RN-C stated her administrator stated he would speak with RN-A and investigate, then on 2/9/26, the administrator informed RN-C that RN-A had located fax documentation in the resident's hard chart from June 2025 showing physician approval of the diagnosis and that his investigation was complete. RN-C stated after that the corporate office had an outside party do an audit of their MDS' and found there were 136 original assessments and 136 modifications, RN-C reported RN-A was put on leave at that time. When RN-A went on leave RN-C was asked to perform the beneficiary denial forms for residents and as she was trying to learn more about this process, she looked at old forms, and for R61 specifically, she noticed the signatures on the denial forms were not what she recognized as being the residents. RN-C stated in early February RN-A made meeting notes for the weekly meetings she was supposed to be having with RN-C regarding her performance, there were			F0895			09/14/2026

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F0895 SS = E	Continued from page 25 supposed to have been eight meetings but only two were held. R40's SCSA MDS dated 10/20/25, didn't identify diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified diagnosis code F33.3. An additional modification was made on 4/13/26 by RN-B, and section I no longer included diagnosis code F33.3. A diagnosis audit report dated 7/31/26, identified R40 had diagnosis F33.3 added to his EMR by RN-A on 12/16/25 at 10:30 a.m. as an effective date of 1/15/25. R40's Physician Update facsimile dated 8/17/25, identified the following, "OK to use F33.3 major depressive disorder with psychotic symptoms related to behaviors, agitation and trazadone use" with a "yes or no" and the "yes" circled and an undated physician signature. R40's progress notes from provider on 3/24/26, includes a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did include a diagnosis for mild late onset Alzheimer's dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. During an interview on 7/30/26 at 1:04 p.m., nurse practitioner (NP)-F stated all faxes go to a central system and the provider signs through that system and the system then keeps a copy of all requests for the resident record. NP-F stated they were familiar with both R40 and R39, they took over care from MD-L towards the end of 2025. NP-F was not aware either resident having the diagnosis major depressive disorder, recurrent, severe with psychotic symptoms (F33.3). NP-F reviewed both resident records and confirmed that diagnosis was not on their current or historical diagnosis list. NP-F also stated she was very familiar with MD-L's signature since they worked for the same organization. NP-F reviewed the diagnoses order for R40 dated 8/17/25 and stated the provider signature on the order did not look like MD-L's signature. During an interview on 7/30/26 at 3:33 p.m., RN-I stated on 2/10/26, RN-C had shown her the two faxed orders for R61 and they had the exact same time stamp down to the millisecond of 10:38:17. During an interview on 7/31/26 at 11:48 a.m., the administrator stated they had an internal complaint related to an MDS issue and began reviewing			F0895			09/14/2026

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F0895 SS = E	Continued from page 26 inappropriate documentation inconsistent with providers orders and suspended RN-A pending investigation. After a full investigation, including an external audit of MDS, they didn't substantiate RN-A provided any type of forgery, but did see inconsistencies that they needed to work through. The facility did go through and amend those MDS' to remove the diagnoses F33.3. The administrator stated through the course of this survey he could see there may be more resident signatures in question on the beneficiary notices. The administrator stated the facility did not report this issue to the Minnesota Board of Nursing, he assumed the former MDS coordinator did, and the facility had complied with the requests for documentation submission. The administrator also said they have increased additional auditing and oversight of the MDS submissions. In a timeline received from the facility administrator on 8/3/26, the administrator documented he spoke with RN-A on 2/2/26 about the concern of not having the physician documentation. The administrator also documented RN-A provided him with four copies from the hard charts later this week, one of them was the R61 example from RN-C. The administrator also noted he had met with MD-K, the primary care provider for R61, on 2/24/26 and reviewed the two faxes from 6/24/25. MD-K stated that R61 did have a diagnosis of F33.3. MD-K stated she found it unusual her signature would be exact as she signed everything individually and did not use a copy for her signature. MD-K also found it unusual on the F33.3 diagnosis fax she didn't circle the "yes" completely as she always made sure when circling it was a clear circle so that it showed up when faxed. MD-K was going to have her office review the fax timestamps to see how many were sent to the facility. MD-K stated it was not unusual to send multiple faxes at the same time. MD-K's office was unable to locate either fax in her system but stated it was possible her team did not scan them in. On 2/9/26, (approximate date), the administrator documented he let RN-C know he was able to find the physician forms and they looked fine and had signatures, but he wasn't able to find supporting documentation so RN-C did the right thing to not code it on the MDS. On 2/17/26, the administrator documented that he met with RN-A and reviewed what he had found with the F33.3 issue without supporting documentation. During this meeting, RN-A discussed that one of the forms were brought up during RN-A's Board of Nursing call about concerns of a discrepancy of physician signatures. On 2/18/26, he obtained faxes			F0895			09/14/2026

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F0895 SS = E	Continued from page 27 for R61 from the pharmacy and noted one of the forms to be on a similar form as the physician update for the major depression diagnosis (F33.3), then suspended RN-A pending investigation for possible discrepancies in documentation and MDS diagnoses. The administrator notified the medical director and senior leadership of the concern and suspension. On 4/2/26 the administrator received the results of the external MDS audit and the VP of HR's investigation. These results indicated that a limited subset of documentation reviewed was directly submitted or associated with the RN-A. Based on the available evidence and audit findings, there was no conclusive determination that the RN-A engaged in fraudulent documentation practices. The concerns identified relate more appropriately to process oversight, documentation standardization, and system-level controls. As a result of these findings, the organization has focused on implementing corrective actions, including strengthening documentation standards, enhancing staff education, improving workflow processes, and increasing audit and oversight mechanisms to ensure ongoing compliance and integrity of the MDS process. An undated consultant report for an MDS integrity audit identified “during the review, certain irregularities, including signature inconsistencies on select documents, were identified and appropriately escalated for further independent review. These findings should be evaluated separately to determine scope and impact. Overall, the audit supports the need for systematic process improvement, staff education, and enhanced oversight controls to ensure sustained compliance and documentation integrity. St. Francis Health Services leadership could address these findings proactively through targeted corrective action and strengthened governance structures.” On 7/31/26 at 11:34 a.m., independent consultant (IC)-M clarified what was meant in the MDS Integrity Audit where it was indicated under the section titled, Identification of Additional Irregularities, “the findings were documented and reported through appropriate external channels in accordance with the consultant's professional and ethical obligations and are formally included in this report as material findings requiring further independent review” was that reports were made to the corporate office who had requested the audit and outside of this facility. IC-M stated they didn't elevate this further because they knew they were making a report. The facility's Quality Improvement Incentive			F0895			09/14/2026

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F0895 SS = E	Continued from page 28 Payment (QIIP) for payment year 2027, identified a baseline for resident antipsychotics at 16.76% with a goal of 10.19% for full incentive. Quarter two notes identified review of antipsychotic medication documentation shows facility in compliance with appropriate diagnosis with supporting documentation. Trending downward from Q1 from 19.65% to 13.02%. The facility's corporate compliance and ethics training was requested but not received.			F0895			09/14/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents were informed of and consented to medications prescribed and given for mental health intervention for 2 of 5 residents (R7, R33) reviewed for unnecessary medications. Findings include: R7: R7's significant change in assessment (SCSA) minimum data set (MDS) dated 7/6/26, identified intact cognition and diagnoses of Parkinsons, anxiety, insomnia, and bipolar disorder.			F0552	F552 – Right to be Informed/Make Treatment Decisions – SS=D R7 and R33's medication records were reviewed. Required informed-consent documentation for psychotropic medications was obtained or updated as applicable. Residents and/or representatives were informed of the medication, indication, risks, benefits, potential side effects, and available alternatives. All current residents receiving psychotropic medications have potential to be impacted by this deficient practice. All current residents receiving psychotropic medications were audited by the DON/designee to identify missing or incomplete informed-consent documentation. Identified deficiencies were corrected. DON/designee reviewed the Psychotropic Medications policy with no changes needed. Licensed nurses were educated by the DON/designee on the Psychotropic Medications policy, regarding psychotropic medication informed consent and the requirement that residents/representatives be informed and consent obtained/documented consistent with facility policy before treatment, except where otherwise permitted by law. The DON/designee will audit 5 residents receiving psychotropic medications weekly for 4 weeks and monthly for 2 months beginning the week of 9/7/26 to ensure they have informed-consents completed for psychotropic medication use. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0552 SS = D	Continued from page 29 R7’s care plan dated 4/9/26, identified a focus statement for behavior related to bipolar disorder and anxiety. Interventions include target behaviors, non-pharmacological interventions, to administer medications per order and monitor for side effects. R7’s provider order on 7/21/26, Depakote 250 milligrams (mg) by mouth two times per day for bipolar disorder. And an order on 5/31/26, gabapentin 300 mg by mouth three times per day for anxiety. R7’s electronic medical record (EMR) didn’t contain evidence of R7 having been educated on the risks, benefits, side effects, and alternatives for Depakote or gabapentin which were both treating mental health diagnoses. R33: R33’s significant change Minimum Data Set (MDS) dated 6/9/26, identified R33 had diagnoses which included Parkinson’s disease, polyneuropathy, depression, and anxiety. In addition, R33’s MDS identified he was severely cognitively impaired, was dependent on staff for activities of daily living, and received antianxiety medications, opioids, and anticonvulsants. R33’s Order Summary Report identified he had orders for the following medications: Celexa 20 milligrams (mg) one time a day for major depressive disorder Hydroxyzine 10 mg two times a day for hallucinations/delusions related to Parkinson’s disease Risperidone 0.25 mg at bedtime for hallucinations related to major depressive disorder. A review of R33’s electronic medical record (EMR) identified R33 had a consent for Celexa, but not for hydroxyzine or risperidone. During an interview on 7/30/26 at 12:12 p.m., the director of nursing (DON) stated it was important for residents and/or their families to know the side effects and the risk for taking the medication to decide if the risk was worth taking the medication. Psychotropic Medications dated 5/21/25, identified care center nursing staff would review the psychotropic medication informed consent with the			F0552			09/14/2026

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F0552 SS = D	Continued from page 30 resident and/or representative and then would obtain a signature for use of the medication(s). Psychotropic medications were defined as anti-anxiety, hypnotic/sedative, antipsychotic, anticonvulsant, antihistamine, and antidepressant classes of drugs.			F0552			09/14/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to follow a self-administration of medication (SAM) form which indicated the resident should not self-administer medications. This affected 1 of 1 (R54) residents reviewed for self-administration of medications. Findings include: R54's quarterly Minimum Data Set (MDS) dated 5/21/26, indicated R25 had no cognitive impairment. Diagnoses included anemia, multiple sclerosis, and seizure disorder. R54's Active Order Summary Report dated 7/30/26, lacked orders to keep any medications at bedside. R54's care plan dated 9/3/25, indicated R54 was unable to self-administer medications. Interventions included nursing responsibility to document, administer, and store all medications. R54's Self Administration of Medication (SAM) Evaluation form dated 8/21/25, indicated R54 could not self-administer medications and could not keep medications at bedside. On 7/27/26 at 4:18 p.m., medications including a tube of Diclofenac muscle cream, Biotin mouth wash, and Systane eye drops were observed on R54's bedside table. No staff were in the room.			F0554	F554 – Resident Self-Administration of Medications – SS=D R54's medications and self-administration status were immediately reviewed. Medications were removed from bedside. R54's self-administration assessment and care plan were reviewed and updated as applicable. All other residents have potential to be impacted by this deficient practice. Resident rooms were reviewed to identify medications maintained at bedside by DON/designee. Residents with bedside medications were reviewed to ensure an appropriate self-administration assessment, IDT determination were completed, and order to keep at bedside obtained. DON reviewed the Self-Administration of Medications by Resident policy with no changes needed. Licensed nurses were educated by the DON/designee on the Self-Administration of Medication by Resident policy, and that medications may not be maintained at bedside for self-administration unless the resident has been assessed and approved according to facility policy. The DON/designee will conduct random room observations for medications at bedside to ensure compliance with facility policy, two times a week for 4 weeks and monthly for 2 months beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0554 SS = D	Continued from page 31 On 7/30/26 at 9:02 a.m., the same medications were again observed on R54's bedside table and there were no staff present. During an interview on 7/30/26 at 9:05 a.m., licensed practical nurse (LPN)-A stated a SAM assessment and orders from the provider to keep at bedside are needed prior to leaving medications at bedside. LPN-A confirmed Diclofenac, Biotin, and Systane were left in R54's room, but was unsure if R54 should have them left at bedside. During an interview on 7/30/26 at 9:29 a.m., registered nurse (RN)- D stated the RN did the SAM assessments. Once completed, the RN would let licensed staff know who could keep medications at bedside. RN-D reviewed R54's SAM assessment and acknowledged R54 should not have medications left at bedside. During an interview on 7/30/26 at 9:40 a.m., the director of nursing (DON) stated an expectation staff would make sure all appropriate paperwork, such as the SAM assessment, were completed and accurate prior to leaving medication at bedside. Facility policy Self-Administration of Medication by Residents last revised 2/27/24, indicated the SAM assessment would be completed and reviewed by the interdepartmental team (IDT). A decision would be made by the IDT prior to keeping medications at bedside.			F0554			09/14/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).			F0578	F578 – Request/Refuse/Discontinue Treatment; Advance Directives – SS=D R5 no longer resides at the facility. All residents have the potential to be impacted by this deficient practice. All current residents POLST were reviewed by DON/designee to ensure they were signed by the Provider per facility policy. Identified concerns were corrected with the resident/representative and Provider. DON reviewed the Advance Care Planning policy with no changes needed. DON/designee educated all registered nurses on the Advance Care Planning policy, regarding completion per facility policy, including provider authentication.		09/14/2026

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F0578 SS = D	Continued from page 32 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 resident's (R5) Provider Orders for Life Sustaining Treatment (POLST) was completed timely. Findings include: R5's admission Minimum Data Set (MDS) dated 5/13/26, identified R5 had diagnoses which included heart failure (a medical condition where the heart does not pump blood effectively), dementia, diabetes mellitus, hyperlipidemia, and heart disease. In addition, R5's MDS identified they were moderately cognitively intact and required partial to moderate assistance with activities of daily living. R5's POLST identified R5 signed their POLST document on 5/6/26, R5's provider did not sign the document until 7/30/26, after it was brought to the facility's attention that the document had not been signed by the provider. During an interview on 7/30/26 at 1:02 p.m., the director of nursing (DON) stated the admission coordinator would fill out the form with the resident			F0578	Continued from page 32 The DON/designee will audit 3 resident POLST weekly for 4 weeks and monthly for 2 months that it was completed timely beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0578 SS = D	Continued from page 33 or their decision maker and then it would go into the chart as an order. The DON could not say why the POLST had not been signed by the provider on admission.			F0578			09/14/2026
F0582 SS = D	Advance Care Planning dated 6/25/24, identified on admission the resident and/or their legal representative would be notified of the need for an order for cardiopulmonary resuscitation. The policy identified the POLST would become a medical order. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident			F0582	F582 – Medicaid/Medicare Coverage/Liability Notice – SS=D R78 no longer resides at the facility. All residents who are being discharged from Medicare or managed-care non-coverage have potential to be impacted by this deficient practice. Residents who recently received Medicare or managed-care non-coverage determinations starting from 8/1/2026 were reviewed by MDS Coordinator/designee to verify that required notices were provided timely and that receipt was documented. DON reviewed the Medicare Denial ABN Procedures policy with no changes needed. Social services were educated by the MDS Coordinator/designee on the Medicare Denial ABN Procedures policy regarding beneficiary-notice requirements, including timely delivery, explanation of appeal rights, obtaining valid acknowledgement/signature, and documentation of delivery. The MDS Coordinator/designee will audit all beneficiary non-coverage notices weekly for 4 weeks and monthly for 2 months to verify timely delivery and documentation beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0582 SS = D	Continued from page 34 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents received notice of Medicare non-coverage for 1 of 4 residents (R78) reviewed for beneficiary denials. Findings include: A Medicare notice of non-coverage is required to be given to residents in advance of non-coverage for services covered under Medicare so that they have an opportunity to appeal the decision. R78's Admission Record identified and admission date of 8/21/25, and a discharge date of 9/10/25. A review of R78's Financial Questionnaire from admission, identified R78's signature on the financial form. R78's Medicare denial form (CMS-10123) dated 9/5/25 and a managed care denial form (U Care) dated 9/7/25, contained R78's signatures, the signatures on each form didn't look similar to each other, and the signature on the 9/7/25 U Care form didn't look similar to the Financial Questionnaire form. R78's progress notes didn't reflect R78 had received their Medicare or UCare denial forms. During an interview on 7/31/26 at 10:44 a.m., R78 stated she did not recall signing any papers about Medicare denial and the right to appeal. R78 stated she was at the facility 21 days and is home and doing well. Beneficiary denial forms for additional residents more recently receiving beneficiary denials were requested but not received. Based on interview and			F0582			09/14/2026

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F0582 SS = D	Continued from page 35 document review, the facility failed to ensure residents received notice of Medicare non-coverage for 1 of 4 residents (R78) reviewed for beneficiary denials.			F0582			09/14/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to immediately report incidents of potential resident-to-resident abuse to the state agency (SA) within two hours, as required for 1 of 1 residents (R71) reviewed for abuse. In addition, the facility failed to ensure potential sexual abuse were reported to the state agency (SA), within 2 hours, for a resident with unexplained laceration of perineum for 1 of 1 resident (R43) reviewed for injuries of unknown cause. Findings include: R71:			F0609	F609 – Reporting of Alleged Violations – SS=D R71 and R43 no longer reside at the facility. Current residents involved in allegations or suspicious injuries were reviewed by the Administrator/DON to determine required reporting and follow-up. Any current reportable concerns identified during the review were reported in accordance with applicable reporting requirements. All residents have potential to be impacted by this deficient practice. Incident reports, injuries of unknown origin, resident-to-resident incidents, allegations of abuse/neglect, and other potentially reportable events will be completed timely in accordance with applicable reporting requirements. Administrator reviewed the Maltreatment Investigation and Reporting policy and Maltreatment Definitions form with no changes needed. All staff were educated on the Maltreatment Investigation and Reporting policy and Maltreatment Definitions by the DON/designee regarding immediate reporting of suspected abuse, neglect, exploitation, mistreatment, resident-to-resident abuse, and suspicious injuries/injuries of unknown source. Licensed nurses and administrative staff received additional education regarding required external reporting timeframes and agencies. The Administrator/designee will audit incident reports and 24-hour reports weekly for 4 weeks and monthly for 2 months to verify timely internal and external reporting based on facility policy beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0609 SS = D	Continued from page 36 R71's admission Minimum Data Set (MDS) dated 12/24/25, indicated R71 was cognitively intact. Diagnoses included osteoarthritis of the right hip and major depressive disorder. R71's care plan dated 12/24/25, indicated R71 was a vulnerable adult related to physical condition. Goals included the resident would be free abuse, neglect, or financial exploitation. Interventions lacked interventions to protect from abuse. R71's progress notes from 12/25/25 to 12/30/25, were reviewed and showed the following: 12/27/25 at 2:28 p.m., R71 approached nurse and reported R72 was in her room multiple times the night before and scared R71. R71 stated R72 had grabbed some belongings and left the room. Director of Nursing (DON) was notified of the situation. 12/30/25 at 1:00 a.m., R71 two nights in a row placed a walker in front of the door to barricade R72 from entering room. R71 stated " I'm scared to death of him". R71 had put the call light on at the beginning of the shift to report R had already attempted to enter R71's room R72's admission MDS dated 12/9/25, indicated R72 had moderate cognitive impairment. Diagnoses included vascular dementia with agitation and Alzheimer's disease. The MDS indicated R72 paced and wandered daily and significantly disrupted the care or living environment of other residents. R72's progress notes from 12/25/25 to 12/30/25, were reviewed and indicated frequent roaming into other resident rooms and frequent agitation towards staff and residents. During an interview on 7/29/26 at 11:27 a.m., licensed practical nurse (LPN)-A stated R71 came to her on the morning of 12/26/25, and reported R72 had come into the room several times the night before. When R71 told R72 to leave the room, R72 snarled at R71, grabbed R71's blanket, and then left the room. LPN-A stated R71 told her R71 was very scared of R71. The DON was notified of the resident-on-resident altercation. Any nursing staff can file the vulnerable adult (VA) report but when reported the DON did not tell her to go ahead and file a VA report with the state agency (SA) or that the DON was going to file the VA with the state			F0609			09/14/2026

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F0609 SS = D	Continued from page 37 agency. During an interview on 7/29/26 at 11:39 a.m., the DON stated on 12/26/25, she was not the DON, but the evening charge nurse. She had been made aware of the situation but was unsure if the DON at the time had filed a VA with the SA. The DON stated a resident-on-resident altercation with concerns of abuse should be reported to the SA within two hours of finding out about it. During an interview on 7/30/26 at 9:40 a.m., the administrator stated a VA had not been filed with the SA because the facility did not feel the concern reached the level of resident-on- resident potential abuse. Facility policy Maltreatment Investigation and Reporting dated 3/10/26 indicated any employee who observed, suspected, or had knowledge of maltreatment or suspicious injury involving a Vulnerable Adult must immediately report their concerns. All alleged violations that involved abuse would be reported to the SA within 2 hours. R43: R43’s quarterly Minimum Data Set (MDS) dated 7/20/26, identified R43 had diagnoses which included ulcerative colitis, cirrhosis of liver, depression, hypothyroidism, hypertension, edema, osteoarthritis, and history of malignant neoplasm of other parts of the uterus. In addition, R43 was cognitively intact, had no behaviors, required substantial to maximum assistance with activities of daily living, and was frequently incontinent of bladder. R43’s care plan was reviewed on 7/29/26, (the document was requested but not provided). R43’s care plan identified she had a self-care deficit and required assistance every four hours and as needed for check and change. The care plan further identified she required help to clean peri area with each incontinence episode. R43’s progress note dated 7/25/26 at 6:47 a.m., identified the facility received a call from an emergency room nurse and identified the following, “She doesn’t have active bleeding, but when you wipe her there is a small amt of blood on the wipe. Informed Nurse res has been having bleeding for a couple of days and has had this issue in the past. Res returned to facility at 0005.” The note went on to identify the following, “. Spoke with resident			F0609			09/14/2026

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F0609 SS = D	Continued from page 38 about cares and asked if anyone has ever been rough when washing her up, providing cares, or abusive in any way. Res loudly stated, "NO!" Res understood it is this writer's job to ask these questions to be sure someone did not cause her any type of injury that may have caused her to have bleeding. Res again so "no". Res AVS (after visit summary) listed a dx (diagnosis) of laceration to perineum." A review of the emergency room encounter dated 7/27/26, for the visit on 7/24/26, identified a complicated urinary tract infection, laceration of perineum in female, fecal occult blood test positive, swelling of right upper extremity. The physical exam identified the following, "Does have very minor labial tear abrasion at the 12 o'clock position with minimal blood present." The summary identified the need for "Good perineal care for laceration". During an interview on 7/28/26 at 3:01 p.m., nursing assistants (NA)-E and NA-F stated they had not been told anything specific about cares for R43 after her emergency room (ER) visit with the exception to be "more gentle". During an interview on 7/30/26 at 10:00 a.m., NA-G stated she had not received any education about peri cares for R43 after her emergency room visit. During an interview on 7/30/26 at 12:18 p.m., the director of nursing (DON) stated the registered nurse (RN) called her the night R43 returned from the ER, the DON stated she called the administrator and they discussed the concern. They determined it was not reportable based on a "similar situation in May or June" but stated it was a different area. The DON stated that one had been investigated. They stated when R43 returned from the ER someone asked her if she had been abused and she said no, based on this information they determined this was not reportable and they decided they did not need to do an investigation. The DON stated they did not do any education or training for staff and stated in retrospect maybe they should have reported and investigated the labial tear/abrasion. During an interview on 7/30/26 at 1:32 p.m., the administrator stated abuse, neglect, injuries of unknown origin should be reported and investigated. He stated they did not feel R43's injury of unknown origin needed to be reported or investigated. Maltreatment Investigation and Reporting dated 3/10/26, identified staff needed to report within 24 hours if the allegation did not involve abuse and did			F0609			09/14/2026

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F0609 SS = D	Continued from page 39 not result in bodily injury.		F0609			09/14/2026	
F0610 SS = D	Maltreatment Prohibition Definitions dated 6/16/26, injuries of unknown source should be reported when the source of the injury was not observed by any person or the source of the injury could not be explained and if the injury was suspicious or the location of the injury was not generally vulnerable to trauma. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to conduct a formal investigation into the allegations of resident-on-resident mental abuse for 1 of 4 residents reviewed (R71) for abuse. The facility also failed to investigate a possible sexual abuse when a resident had unexplained laceration of perineum. This affected 1 of 4 residents (R43) reviewed for abuse. Findings include: R71: R71's admission Minimum Data Set (MDS) dated 12/24/25, indicated R71 was cognitively intact. Diagnoses included osteoarthritis of the right hip and major depressive disorder.		F0610	F610 – Investigate/Prevent/Correct Alleged Violation – SS=D R71 and R43 no longer reside at the facility. The facility reviewed the incidents involving R71 and R43 and completed follow-up to the extent possible. Current residents involved in allegations or suspicious injuries will receive immediate protective interventions pending investigation. All residents have potential to be impacted by this deficient practice. Allegations of abuse, neglect, mistreatment, exploitation, injuries of unknown origin, and resident-to-resident incidents will have protective measures implemented and investigations completed. Administrator reviewed the Maltreatment Investigation and Reporting policy with no changes needed. Licensed nurses and administrative staff were educated on the Maltreatment Investigation and Reporting policy, regarding the facility investigation process, including immediate resident protection, evidence preservation, interviews, record review, identification of root cause, completion of the investigation, required notifications, and corrective actions by the DON/designee. The Administrator/designee will review all allegations and potentially reportable incidents weekly for 4 weeks and monthly for 2 months to verify complete investigation and immediate protection beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026	

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F0610 SS = D	Continued from page 40 R71's care plan dated 12/24/25, indicated R71 was a vulnerable adult related to physical condition. Goals included the resident would be free abuse, neglect, or financial exploitation. Interventions lacked interventions to protect from abuse. R71's progress notes from 12/25/25 to 12/30/25, were reviewed and showed the following: 12/27/25 at 2:28 p.m., R71 approached nurse and reported R72 was in her room multiple times the night before and scared R71. R71 stated R72 had grabbed some belongings and left the room. Director of Nursing (DON) was notified of the situation. 12/30/25 at 1:00 a.m. R71 two nights in a row placed a walker in front of the door to barricade R72 from entering room. R71 stated " I'm scared to death of him". R71 had put the call light on at the beginning of the shift to report R had already attempted to enter R71's room R72's admission MDS dated 12/9/25, indicated R72 had moderate cognitive impairment. Diagnoses included vascular dementia with agitation and Alzheimer's disease. The MDS indicated R72 paced and wondered daily and significantly disrupted the care or living environment of other residents. R72's progress notes from 12/25/25 to 12/30/25, were reviewed and indicated frequent roaming into other resident rooms and frequent agitation towards staff and residents. During an interview on 7/29/26 at 11:27 a.m., licensed practical nurse (LPN)-A stated R71 came to her on the morning of 12/26/25, and reported R72 had come into the room several times the night before. When R71 told R72 to leave the room, R72 snarled at R71, grabbed R71's blanket, and then left the room. LPN-A stated R71 told her R71 was very scared of R71. The DON was notified of the resident-on-resident altercation. The facility process is once the DON is notified of alleged physical, sexual, or mental abuse administration is notified, and management will perform any investigations that would occur. LPN-A stated the DON or any other member of the management team came in that weekend to start an investigation. During an interview on 7/29/26 at 11:39 a.m., the DON stated on 12/26/25, she was not the DON, but the evening charge nurse. She had been made aware			F0610			09/14/2026

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F0610 SS = D	Continued from page 41 of the situation but was unsure if the DON at the time had performed any kind of investigation into the alleged resident on resident mental abuse concerns. During an interview on 7/30/26 at 9:40 a.m., the administrator stated a VA had not been filed with the SA because the facility did not feel the concern reached the level of resident-on- resident potential abuse. For that reason, there was no investigation, other than discussed in the Inter-departmental team (IDT). The IDT notes for the week of 12/26/25 to 12/30/25 were requested but not provided. R43: R43's quarterly Minimum Data Set (MDS) dated 7/20/26, identified R43 had diagnoses which included ulcerative colitis, cirrhosis of liver, depression, hypothyroidism, hypertension, edema, osteoarthritis, and history of malignant neoplasm of other parts of the uterus. In addition, R43 was cognitively intact, had no behaviors, required substantial to maximum assistance with activities of daily living, and was frequently incontinent of bladder. R43's care plan was reviewed on 7/29/26, (the document was requested but not provided). R43's care plan identified she had a self-care deficit and required assistance every four hours and as needed for check and change. The care plan further identified she required help to clean peri area with each incontinence episode. R43's progress note dated 7/25/26 at 6:47 a.m., identified the facility received a call from an emergency room nurse and identified the following, "She doesn't have active bleeding, but when you wipe her there is a small amt of blood on the wipe. Informed Nurse res has been having bleeding for a couple of days and has had this issue in the past. Res returned to facility at 0005." The note went on to identify the following, ". Spoke with resident about cares and asked if anyone has ever been rough when washing her up, providing cares, or abusive in any way. Res loudly stated, "NO!" Res understood it is this writer's job to ask these questions to be sure someone did not cause her any type of injury that may have caused her to have bleeding. Res again so "no". Res AVS (after visit summary) listed a dx (diagnosis) of laceration to perineum." A review of the emergency room encounter dated			F0610			09/14/2026

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F0610 SS = D	Continued from page 42 7/27/26, for the visit on 7/24/26, identified a complicated urinary tract infection, laceration of perineum in female, fecal occult blood test positive, swelling of right upper extremity. The physical exam identified the following, “Does have very minor labial tear abrasion at the 12 o'clock position with minimal blood present.” The summary identified the need for “Good perineal care for laceration”. During an interview on 7/28/26 at 3:01 p.m., nursing assistants (NA)-E and NA-F stated they had not been told anything specific about cares for R43 after her emergency room (ER) visit with the exception to be “more gentle”. During an interview on 7/30/26 at 10:00 a.m., NA-G stated she had not received any education about peri cares for R43 after her emergency room visit. During an interview on 7/30/26 at 12:18 p.m., the director of nursing (DON) stated the registered nurse (RN) called her the night R43 returned from the ER, the DON stated she called the administrator and they discussed the concern. They determined it was not reportable based on a “similar situation in May or June” but stated it was a different area. The DON stated that one had been investigated. They stated when R43 returned from the ER someone asked her if she had been abused and she said no, based on this information they determined this was not reportable and they decided they did not need to do an investigation. The DON stated they did not do any education or training for staff and stated in retrospect maybe they should have reported and investigated the labial tear/abrasion. During an interview on 7/30/26 at 1:32 p.m., the administrator stated abuse, neglect, injuries of unknown origin should be reported and investigated. He stated they did not feel R43’s injury of unknown origin needed to be reported or investigated. Maltreatment Investigation and Reporting dated 3/10/26, identified staff needed to report within 24 hours if the allegation did not involve abuse and did not result in bodily injury. In addition, an initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the Office of Health Facility Complaints or the Minnesota Adult Abuse Reporting Center. The internal process included interviews with residents, staff, and visitors. The process also included immediate interventions taken to protect the resident(s).			F0610			09/14/2026

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F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			F0628	F628 – Discharge Process – SS=D R7's hospitalization/transfer documentation was reviewed. Because the cited transfer had already occurred, the missing notice could not be provided prospectively. The resident/representative was provided with current information regarding the facility's bed-hold/return policy as applicable. All residents have the potential to be impacted by this deficient practice. Recent hospital transfers were reviewed by the DON/designee going back to 9/1/26, to determine whether residents/representatives received required written transfer and bed-hold notices. DON reviewed the Bed Hold Election and Hospital Transfer policy with no changes needed. Licensed nurses and social services staff were educated on the Bed Hold Election and Hospital Transfer policy, regarding required transfer documentation, including written transfer notices and bed-hold information at the time of transfer by the DON/designee. The DON/designee will audit 3 hospital transfers or all transfers if fewer than 3 weekly for 4 weeks and monthly for 2 months beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0628 SS = D	Continued from page 44 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the			F0628			09/14/2026

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F0628 SS = D	Continued from page 45 mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with			F0628			09/14/2026

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F0628 SS = D	Continued from page 46 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide the required written notices before a transfer to the hospital for 1 of 1 resident (R7) reviewed for hospitalization. Findings include: R7’s significant change in condition assessment (SCSA) minimum data set (MDS) dated 7/6/26, identified intact cognition and diagnoses of right-side affected hemiplegia and hemiparesis, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). R7’s progress notes dated 7/27/26, didn’t include information regarding a bed-hold. During an interview on 7/30/26 at 1:25 p.m.,			F0628			09/14/2026

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F0628 SS = D	Continued from page 47 registered nurse (RN)-E stated they would ask the resident or representative if they would want a bed-hold and then they let social services director (SS)-C know. RN-E stated the nurses didn't use a form; she thought SS-C went over the form. During an interview on 7/30/26 at 1:26 p.m., SS-C stated the charge nurse would ask family if they would like a bed-hold and then make a progress note regarding verbal bed-hold obtained, when SS-C was back in the office she would send out the bed-hold form and policy and return envelope to sign and send back to them. SS-C stated no paperwork goes to the hospital with the resident, and they only did bed-holds if the resident was admitted. A policy, Bed Hold Election and Hospital Transfer 9/23/25, identified its purpose was to ensure residents and their representatives were informed of their right to elect a bed hold during hospitalization or a therapeutic leave. For a hospital leave transfer to the emergency department, the bed hold policy will accompany the resident. The resident and or representative will be contacted for verbal authorization to accept or decline the bed hold. A copy of the policy and completed consent will be mailed within 24 hours.			F0628			09/14/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.			F0641	F641- Accuracy of Assessments The MDS assessments and medical records of the residents identified in the deficiency were reviewed and corrected as appropriate to ensure accurate, complete, and supported MDS coding. All residents have the potential to be impacted by this deficient practice. Current residents' most recent MDS assessments will be reviewed by the MDS Coordinator/designee for completeness, timeliness, and accuracy, including verification that diagnoses coded on the MDS are supported by the medical record. MDS Coordinator reviewed the MDS 3.0 Assessments policy with no changes needed. Staff responsible for completing MDS sections were educated by the MDS Coordinator/designee on the MDS 3.0 Assessments policy, regarding accurate and complete assessment, supporting documentation, required completion timeframes, and certification of assessment accuracy. The MDS Coordinator/designee will audit 3 MDS assessments weekly for 4 weeks, then monthly for 2 months for accuracy, completeness, timeliness, and		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0641 SS = D	Continued from page 48 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the minimum data sets (MDS) was completed accurately and timely for 1 of 3 residents (R25) reviewed for activities of daily living, and 1 of 4 residents (R69) reviewed for quality of care and 1 of 1 resident (R43) for oral/dental. In addition, the facility failed to ensure the integrity of MDS data submitted to the Centers for Medicare and Medicaid Services (CMS) for 4 of 4 residents (R31, R39, R40, R61) reviewed for MDS accuracy. Findings include: R25: Per the Centers for Medicare and Medicaid Services (CMS) and the resident assessment instructions (RAI) manual, a significant change in assessment (SCSA) must be completed less by the end of the 14th day following determination that a significant change has occurred or 14 days after the assessment reference date (ARD). R25's SCSA MDS with an ARD of 4/9/26, identified moderately impaired cognition and diagnoses of malignant neoplasm of lung, and secondary neoplasm of bone. The RN assessment coordinator signed as complete on 4/28/26. Section GG for functional limitation in range of motion was not assessed. During an interview on 7/30/26 at 11:24 a.m., registered nurse (RN)-H, who identified as the MDS coordinator, stated there wasn't date from the nursing staff to be able to code section GG of the MDS. RN-H stated it would be important for section GG to be completed to know the resident's baseline and for billing purposes.			F0641	Continued from page 48 supporting documentation beginning the week of 9/7/26. Identified concerns will be corrected and addressed with appropriate staff. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0641 SS = D	Continued from page 49 R31 R31's Admission Record identified an admission date of 1/25/23. R31's quarterly minimum data set (MDS) dated 11/5/25, didn't contain diagnosis for major depressive disorder, recurrent, severe with psychotic symptoms (F33.3) in section I. On 12/16/25, RN-A modified the 11/5/25 MDS to include diagnosis F33.3 under section I. R31's Diagnosis Audit Report identified F33.3 was added to his EMR on 1/15/25 with an effective date of 1/25/23. A progress note from R31's provider on 4/21/26, included a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did contain a diagnosis for severe Lewy body dementia with agitation, depressive disorder in remission noting resident "can be very happy when alert". R31's progress notes didn't reflect supporting documentation for the F33.3 diagnosis that was added to his medical records. R31's medical record lacked supporting documentation for diagnosis F33.3. A provider order for R31's F33.3 diagnosis was requested but not received. R39 R39's SCSA MDS dated 10/18/23, completed by RN-A included diagnosis F33.3. R39's history and physical dated 8/13/23, identified a diagnosis of late onset Alzheimer's disease without behavioral disturbance and generalized anxiety disorder, but didn't contain diagnosis F33.3. R39's Diagnosis Audit Report identified F33.3 was added to her record on 1/15/25 with an effective date of 8/17/23. R39's medical record lacked supporting documentation for diagnosis F33.3. A provider order for diagnosis F33.3 was requested but not received. R40 R40's SCSA MDS dated 10/20/25, didn't identify			F0641			09/14/2026

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F0641 SS = D	Continued from page 50 diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified diagnosis code F33.3. An additional modification was made on 4/13/26 by RN-B, section I didn't identify diagnosis code F33.3. A diagnosis audit report dated 7/31/26, identified R40 had diagnosis F33.3 added to his EMR by RN-A on 12/16/25 at 10:30 a.m. as an effective date of 1/15/25. R40's Physician Update facsimile dated 8/17/25, identified the following, "OK to use F33.3 major depressive disorder with psychotic symptoms related to behaviors, agitation and trazadone use" with a "yes or no" and the "yes" circled and an undated physician signature. R40's progress note from provider on 3/24/26, includes a review of systems and diagnoses for a regulatory visit and didn't include F33.3, but did include a diagnosis for mild late onset Alzheimer's dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. R40's medical record lacked supporting documentation for diagnosis F33.3. R43: R43's quarterly MDS dated 7/20/26, identified section L oral/dental, was not completed (it was left with dashes). During an interview on 7/29/26 at 1:27 p.m., RN-H reviewed R43's MDS and verified section L was missing information. RN-H stated it should have been completed and stated it would be important to have the information so any changes could be reviewed at the next assessment. During an interview on 7/30/26 at 11:59 a.m., the director of nursing (DON) verified the MDS assessments needed to be completed for coding, billing, and to develop the residents care plans. MDS 3.0 Assessment dated 8/20/24, identified all MDS assessments and Discharge and Reentry records would be completed following the Resident Assessment Instrument (RAI) instructions. The RAI further identified all items should be completed and signed within the required time frames according to the RAI Manual. R61			F0641			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0641 SS = D	Continued from page 51 R61's SCSA MDS dated 10/16/25, didn't identify a diagnosis code F33.3 in section I. A modification was made on 12/16/25 by RN-A, and section I identified a diagnosis code of F33.3. An additional modification was made on 4/13/26 by RN-B, section I didn't identify diagnosis code F33.3. R61's Order Summary Report dated 11/25/25, didn't include a diagnosis for F33.3. A diagnosis audit report dated 7/31/26, identified R61 had diagnosis F33.3 added to her EMR by RN-A on 12/16/25 at 10:36 a.m. as an effective diagnosis beginning on 1/22/25. R61's medical record lacked supporting documentation for diagnosis F33.3. R69: R69's admission Minimum Data Set (MDS) dated 8/13/25, identified section C cognitive patterns, section D mood had not been assessed. Section E behavior was missing assessments. During an interview on 7/29/26 at 1:25 p.m., registered nurse (RN)-H reviewed R69's admission MDS and verified sections C, D, and E were missing information. RN-H stated social services would usually complete sections C, D, and E. RN-H verified it was important to have all sections completed for a baseline assessment so they could compare them at the next assessment. During an interview on 7/31/26 at 11:48 a.m., the administrator stated they had an internal complaint related to an MDS issue and began see inconsistencies that they needed to work through. The facility did go through and amend those MDS' to remove the diagnoses F33.3.			F0641			09/14/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			F0656	F656 – Develop/Implement Comprehensive Care Plan – SS=D R2 no longer resides at the facility. All residents receiving dialysis have potential to be impacted by this deficient practice. Residents receiving dialysis were reviewed by DON/designee to verify the comprehensive care plan includes dialysis, dialysis-related needs, monitoring, goals, interventions, access-site considerations, and other resident-specific needs as applicable.		09/14/2026

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F0656 SS = D	Continued from page 52 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to include dialysis to a resident's comprehensive care plan, who received dialysis while in the facility. This affected 1 of 1 (R2) residents reviewed for comprehensive care plans. Findings include: R2's quarterly Minimum Data Set (MDS) dated 7/10/26, indicated R2 was cognitively intact. Diagnoses included anemia, hypertension, and end stage renal disease. Section O: Special Treatments, Procedures, and Programs indicated R2 received			F0656	Continued from page 52 DON reviewed the Person Centered Care Planning policy with no changes needed. All staff who update resident care plans were educated by the DON/designee on the Person Centered Care Planning policy regarding development of comprehensive person-centered care plans that address all conditions, treatments, and specialized services identified through the comprehensive assessment, including addressing dialysis. The DON/designee will audit 3 care plans weekly for 4 weeks and monthly for 2 months, including residents receiving dialysis beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0656 SS = D	Continued from page 53 dialysis while at the facility. R2’s Active Order Summary Report dated 7/30/26, indicated an order to monitor perma-catheter site for pain, swelling, or signs of infection. The order summary report lacked orders related to R2’s dialysis. R2’s care plan lacked a care plan related to R2’s dialysis and interventions to treat the dialysis, until a care plan was initiated on 7/28/26. During an interview on 7/28/26 at 12:49 p.m., R2 stated dialysis was received through the dialysis center in Hibbing, Mn on Tuesday, Thursday, and Saturday. Dialysis was received through the perma-catheter in the right chest wall. During an interview on 7/30/26 at 9:06 p.m., the licensed practical nurse (LPN)-A stated all resident specific medical conditions such as heart conditions, respiratory conditions and kidney conditions, like the need for dialysis, would have their own specific care plans so all staff would be aware of the condition and know how to provide care related to the condition. During an interview on 7/30/26 at 9:29 a.m., registered nurse (RN)-D stated the RN was responsible for building the care plan based on diagnoses and the information in the MDS assessment. RN-D reviewedR2’s MDS assessment from 7/10/26, and R2’s active care plan and acknowledge the MDS assessment showed R2 received dialysis but there was no active care plan related to the Dialysis is R2’s current care plan. During an interview on 7/30/26 at 9:40a.m., the director of nursing (DON) stated all RN’s should make sure the comprehensive care plan has all details related to what is on the comprehensive MDS assessment in the resident's active care plan. The facility policy Person Centered Care Planning dated 6/16/26 indicated a comprehensive person-centered are plan would be completed with 7 days of the MDS completion. The care plan would be based on the MDS assessment and care area assessments. The care plan would cover specialized services and include measurable goals and interventions			F0656			09/14/2026
F0684 SS = D	Quality of Care CFR(s): 483.25			F0684	F684 – Quality of Care – SS=D R28's lymphedema treatment needs and provider		09/14/2026

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F0684 SS = D	Continued from page 54 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure orders were followed as written for 1 of 1 resident (R28) reviewed for quality of care. Findings include: R28's quarterly Minimum Data Set (MDS) dated 7/10/26, identified R28 had diagnoses which included multiple sclerosis (a long-lasting disease of the brain and spinal cord), diabetes mellitus, persistent atrial fibrillation (a common irregular heart rhythm where the upper heart chamber beats fast and out of sync with the lower chambers), hypertension, hyperlipidemia, heart failure (a chronic condition where the heart muscle cannot pump blood and oxygen well enough to meet the body's needs). In addition, R28's MDS identified he was cognitively intact and was dependent on staff for assistance with activities of daily living. During an interview on 7/30/26 at 4:24 p.m., family member (FM)-N expressed concerns about therapies not being continued since the new physical therapy department started. FM-N stated they had talked with the facility about her concerns with lack of therapy. FM-N thought R28's provider had re-ordered the therapy, but he was not receiving any treatment. A physician's update with a date of 7/3/26, identified a family requested an order for the resident to receive lymphedema treatment. The provider responded on 7/7/26, "ok for occupational therapy referral for lymphedema treatments." A review of R28's current orders on 7/30/26, (requested but not provided) identified there were no orders for lymphedema massage. During an interview on 7/31/26 at 8:24 a.m., therapy director (PTA)-A stated R28 had been getting treatment for lymphedema therapy up until May 2026, when the facility changed to a different therapy			F0684	Continued from page 54 communication were reviewed. Provider order for lymphedema treatment was processed in the resident's orders. Facility found a location that would be able to provide this service to R28, but R28 has declined this treatment at this time. All residents have potential to be impacted by this deficient practice. Current residents with therapy referrals, treatment recommendations, or provider communications requiring orders were reviewed by the DON/designee to ensure orders had been received, processed, and implemented. DON created a new Orders Policy on 9/2/26. Licensed nurses were educated on the Orders Policy regarding timely communication, clarification, transcription, and implementation of provider orders and therapy referrals by the DON/designee. The DON/designee will audit 3 new or changed provider orders/therapy referrals weekly for 4 weeks and monthly for 2 months to verify order processing and timely implementation beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0684 SS = D	Continued from page 55 company. PTA-A stated their department had not received any orders for lymphedema therapy for R28. During an interview on 7/31/26 at 8:42 a.m., registered nurse (RN)-E confirmed the order for lymphedema order had been signed off on 7/7/26. During an interview on 7/31/26 at 10:08 a.m., the director of nursing (DON) verified when nursing received a provider order, the order should be entered as an order and not as a progress note. The DON stated if an order is entered as a progress note instead of an order the order will not be carried out. During an interview on 7/31/26 at 10:24 a.m., nurse practitioner (NP)-F stated R28 would probably benefit from lymphedema treatment. NP-F stated she would expect orders to be processed as written.			F0684			09/14/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe ambulation interventions were followed for 2 of 2 residents (R14, R75) reviewed. In addition, the facility failed to ensure resident equipment concerns were addressed in a timely manner to help prevent accidents for 1 of 5 residents (R9) reviewed for accident and safety concerns. Findings include: R14: R14’s significant change Minimum Data Set (MDS) dated 7/3/26, identified R14 was severely cognitively impaired. R14’s diagnoses included acute on chronic			F0689	F689 – Free of Accident Hazards/Supervision/Devices – SS=D R14, R75, and R9 no longer reside at the facility. All residents have the potential to be impacted by the deficient practice. Residents at risk for falls and residents using wheelchairs or other mobility devices were reviewed for appropriate supervision, current interventions, safe equipment, and consistency between therapy recommendations and nursing care plans by the DON/designee. DON reviewed the Transfer Belt Policy with no changes needed. DON reviewed the Resident Concerns policy and updated to reflect the use of Maintenance Care application for Environmental Service communication. Nursing, therapy, and activity staff were educated on the Transfer Belt policy and Resident Concern policy, regarding following transfer/ambulation recommendations, use of gait belts and other safety devices as indicated, reporting malfunctioning equipment, and implementing timely interventions following falls or changes in function by the DON/designee. Administrator/designee also provided education to maintenance staff on addressing resident equipment concerns timely. The DON/designee will audit 3 residents at risk for falls weekly for 4 weeks and monthly for 2 months to ensure safety interventions implemented per plan		09/14/2026

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F0689 SS = D	Continued from page 56 congestive heart failure, acute on chronic respiratory failure with hypoxia, hypertension, atrial fibrillation, difficulties in walking, abnormalities of gait and mobility, and weakness. R14's care plan revised 2/4/26 indicated that R14 required supervision with touching assist of 1 staff for ambulating with front wheeled walker (FWW). R14's physical therapy (PT) treatment encounter notes dated 6/10/26, identified R14 was doing gait training with stand by assist (SBA) without an assistive device, R14 ambulated 150 feet, and sustained a fall as R14's legs could not keep up with the rest of their body. R14's Incident Report Form dated 6/10/26 identified a fall in the hallway near the nurse's station on 6/10/26 at 4:15 p.m. R14 was gait training with therapy staff assist of 1. No assistive device or gait belt was identified in the report. R14's Emergency Room (ER) encounter summary dated 6/11/26 indicated R14 had an acute anterior left third rib fracture. R14 had refused to go to the ER at the time of the fall on 6/10/26. R14's physician encounter note dated 6/15/26 evaluated R14's fracture of left rib following a fall on 6/10/26 and indicated no new orders related to the rib fracture. During an interview on 7/29/26 at 1:34 p.m., the DON stated they were a charge nurse at the time of R14's fall incident on 6/10/26. They observed R14 ambulating past the nurse's station with therapy staff on 6/10/26, heard a crash, and ran into the hallway. R14 was lying in the middle of the hallway, 1 therapy staff was present, R14 had no gait belt and no FWW. During an interview on 7/29/26 at 2:02 p.m., physical therapy assistant (PTA)-A stated that the rehabilitation department's policy was to use a gait belt with any type of transfer or ambulation. PTA-A stated if a resident refused the use of a gait belt, they would explain the risks and benefits of its use, and if a resident continued to refuse, they would not do gait training without a gait belt. PTA-A stated gait belts were an important safety intervention to provide stability and reduce falls. On 7/29/26 at 9:21 a.m., attempted to call the physical therapy assistant that was ambulating the resident at the time of R14's fall on 6/10/26. A voicemail was left but the call was not returned.			F0689	Continued from page 56 of care, including use of gait belt. Administrator/designee will audit 3 resident equipment concerns weekly or all if less than 3 in a week for 4 weeks and monthly for 2 months to ensure concerns were addressed timely beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0689 SS = D	Continued from page 57 R75: R75's 5-day Minimum Data Set (MDS) dated 7/17/26, identified R75 was cognitively intact. R75's diagnoses included fracture of left clavicle, fracture of sternum, and hypertension. R75's care plan revised 7/22/26, identified that R75 was able to ambulate independently with a front wheeled walker (FWW) in their resident room. The care plan did not include instructions for ambulating outside the resident room and it did not include physical therapy (PT) orders. R75's physician orders dated 7/10/26, instructed Physical Therapy Evaluate and Treat as Indicated. R75's PT orders signed 7/22/26, instructed staff to walk R75 with gait belt, FWW, and stand by assist – contact guard assist (SBA-CGA) of 1 to lunch and supper in dining room daily. These orders were observed on the inside of R75's closet door on 7/29/26 at 12:28 p.m. During an observation on 7/29/26 at 12:01 p.m., R75 ambulated independently into the hallway with their FWW. The activities director (AD) met R75 in the hallway and asked where R75 was going. R75 stated they were headed to lunch, but they were not supposed to walk in the hallway alone. AD walked with R75 to the dining area with the FWW but no gait belt. During an observation on 7/29/26 at 12:27 p.m., nursing assistant (NA)-A walked with R75 from the dining table to R75's room with the FWW but no gait belt. During an interview on 7/29/26 at 12:28 p.m., NA-A stated R75 ambulated independently in their room but NA-A was not sure if staff were to use a gait belt when walking with R75 outside the resident's room. NA-A stated PT orders were posted inside resident closet doors, and a copy was kept at the nurse's station. After reviewing R75's PT orders on R75's closet door, NA-A confirmed R75 was SBA of 1 with a FWW and gait belt. NA-A stated they usually use a gait belt when walking with residents to reduce the risk of falls. During an interview on 7/29/26 at 12:34 p.m., the AD stated they forgot to use a gait belt when walking with R75 to the dining area. AD stated gait belts were important to keep hands on residents			F0689			09/14/2026

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F0689 SS = D	Continued from page 58 while walking to help steady them. During an interview on 7/29/26 at 2:09 p.m., physical therapy assistant (PTA)-A stated that each resident had a gait belt on a hook near their resident door. PTA-A expected staff to use a gait belt every time they were walking with a resident. During an interview on 7/29/26 at 1:34 p.m., the director of nursing (DON) stated they expected staff to use safety interventions when ambulating residents including gait belts. They stated a gait belt was important because it allows staff to give more stability to the residents and potentially reduce injury by slowing and controlling a fall. Transfer Belts policy, undated, instructed a transfer belt was to be used when transferring or ambulating any resident who required staff assistance. R9: On 7/27/26 at 2:27 p.m., R9 stated she fell last Saturday night (7/18/26) next to the bed because when she went to get into it the brakes on her wheelchair wouldn't lock and it rolled away. R9 stated maintenance was aware, and nursing staff had left notes and emailed the maintenance guy, but it hadn't gotten fixed. R9 added a male nursing assistant had fixed the wheelchair brake for her after she fell but it had gone bad again and wasn't working at this time. R9 was trying to demonstrate locking her right brake. During an interview on 7/29/26 at 1:08 p.m., NA-B stated R9 had complained about her wheelchair brakes prior to when she fell that Saturday. NA-B didn't recall if or when she put a work order in. During an interview on 7/30/26 at 1:06 p.m., environmental services director (EVS)-H stated he wanted work orders to come strictly from the maintenance app, but some people would leave notes, or tell him when they saw him, so he redirects them to put it on the app. EVS-H stated he prioritized work by resident things if it was affecting the resident or their equipment. EVS-H didn't recall the first time he heard about R9's wheelchair brakes; he heard there were staff who told R9 they put tickets in, but a request wasn't put in until Saturday the 18th and he went that Monday to check on it on and it was working ok at that time. EVS-H added R9 had come to the administrator on the			F0689			09/14/2026

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F0689 SS = D	Continued from page 59 evening of 7/27/26 about her wheelchair, and when EVS-H looked at it he decided to just replace the whole wheelchair. A policy, Resident Concerns dated 1/17/19, identified its purpose was to provide guidelines to staff for following up on resident or representative concerns. Resident concerns related to personal belongings, resident room, equipment, missing items, behaviors, etc. will be reported to the social services department, determined if it was a reportable incident, document on a concern form or other designated place in the medical record and routed to the appropriate department head who will document their follow up and return to social services. Environmental concerns would be reported to the maintenance department on a maintenance slip, logged by maintenance and followed up and documented by maintenance as completed.			F0689			09/14/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure the tube feeding bottle was dated and timed when opened for 1 of 1 resident (R3) reviewed for tube feeding cares.			F0693	F693 – Tube Feeding Management/Restore Eating Skills – SS=D R3's tube-feeding bottle and tubing were replaced/labeled as appropriate. Staff responsible for R3's enteral feeding were instructed to date, time, and initial enteral-feeding products and tubing according to facility policy/manufacturer guidance. All residents receiving enteral nutrition have potential to be impacted by this deficient practice. All residents receiving enteral nutrition were reviewed to verify enteral feeding bottles/formulas and tubing were appropriately dated, timed, and initial according to facility policy/manufacture guidance. DON reviewed the Enteral Feeding Tube policy with no changes needed. Licensed nurses were educated by the DON/designee on the Enteral Feeding Tube policy, regarding enteral-feeding management, including dating, timing, and initialing of enteral feeding products and tubing. The DON/designee will observe enteral-feeding practices for all applicable residents to ensure enteral feeding products and tubing are labeled with the date, time, and initials weekly for 4 weeks and monthly for 2 months beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated.		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
F0693 SS = D	Continued from page 60 Findings include: R3’s quarterly Minimum Data Set (MDS) dated 6/29/26, identified R3 had diagnoses which included hemiplegia/hemiparesis (complete or severe paralysis on one side of the body/mild to moderate weakness on one side of the body), dysphagia (difficulty or discomfort when swallowing foods, liquids, or even saliva), hyperlipidemia, aphasia (a brain disorder that affects how one speaks, reads, writes, and understanding what other people say), hypertension. In addition, R3’s MDS identified she had unclear speech, was severely cognitively impaired, and was dependent on staff for activities of daily living. R3’s MDS also identified R3 received tube feedings. R3’s current physician’s orders reviewed on 7/28/26, identified she had orders for nocturnal feedings Jevity 1.5 at 83 milliliters (ml) per hour from 7:00 p.m. to 7:00 a.m.. The orders were requested but not provided. During an observation on 7/29/26 at 7:15 a.m., R3 was resting in bed with the head of the bed at approximately 30 degrees, Jevity 1.5 was running at 83 ml per hour on a pump. The bottle had no open date or time and the tubing was not dated. During an interview on 7/29/26 at 7:53 a.m., licensed practical nurse (LPN)-A verified the tube feeding bottle was not dated or timed when opened. LPN-A also verified the tubing was undated. LPN-A stated it should be dated and timed to ensure the tube feeding doesn’t hang longer than it should. During an interview on 7/30/26 at 12:29 p.m., the director of nursing (DON) stated it was her expectation that staff would date, time, and initial the tube feeding bottle and tubing to ensure the tube feeding didn’t hang too long. A policy on tube feedings was requested but not provided.			F0693	Continued from page 60 Completion Date: 9/14/26		09/14/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care,			F0695	F695 – Respiratory/Tracheostomy Care and Suctioning – SS=D R7’s oxygen and nebulizer equipment was cleaned and/or replaced as appropriate. Equipment was labeled and stored in a manner that minimizes contamination. Staff providing R7’s respiratory treatments were re-educated regarding equipment cleaning and replacement.		09/14/2026

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F0695 SS = D	Continued from page 61 consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide hygienic care of oxygen and nebulizer equipment for 1 of 1 resident (R7) reviewed for respiratory care. Findings include: R7's significant change in status assessment (SCSA) minimum data set (MDS) dated 7/6/26, identified intact cognition and hemiplegia/hemiparesis r/t subarachnoid hemorrhage right side affected, Parkinsons, CHF, a-fib, COPD, anxiety, GERD, DM, dysphagia, insomnia, bipolar, acute pain, anemia R7's care plan dated 4/10/26 identified oxygen therapy related to acute respiratory failure and CHF. Interventions included oxygen therapy, providing medications as ordered, monitoring for signs and symptoms of respiratory distress and report, oxygen setting at two liters per minute (LPM) to keep oxygen saturations above 88%. R7's provider order dated 11/18/25 identified oxygen at 2 LPM to keep oxygen saturations above 88% every shift. An additional order on 4/2/26 identified oxygen at one to four liters for shortness of breath as needed (PRN). During an observation on 7/27/26 at 3:33 p.m., in R7's room there was a liquid oxygen container with a water bubbler attached; R7 stated he used it at night. The water bubbler was dated 4/2/26. R7 also had a nebulizer mask, chamber and tubing all connected and setting on the bedside table, there was liquid in the chamber. R7 stated he did the nebulizer himself, the nurse set it up and sometimes didn't come back. During an observation on 7/28/26 at 3:04 p.m., in R7's room a nebulizer mask, chamber and tubing were intact on bedside table with condensation in the chamber. During an interview on 7/29/26 at 1:44 p.m., registered nurse (RN)-F stated R7 was alright to administer his own nebulizer, but he needed the nurse to come back to put it back on the nebulizer machine so that was when she cleaned it. RN-F stated the nebulizer should be cleaned after every			F0695	Continued from page 61 All residents with oxygen and nebulizer treatment orders have potential to be impacted by this deficient practice. Residents receiving oxygen and/or nebulizer treatments were reviewed to verify that respiratory equipment was clean, appropriately stored, labeled, and changed at required intervals. Equipment was changed and dated as needed. DON reviewed the Oxygen Administration policy was reviewed with no changes needed. DON created a Nebulizer Policy. Licensed nurses and other applicable staff were educated by the DON/designee on the Oxygen Administration and Nebulizer policies, regarding hygienic management of oxygen and nebulizer equipment, including cleaning after use, appropriate storage, labeling, and scheduled replacement of tubing/cannulas/masks. The DON/designee will observe respiratory equipment for 5 residents or all applicable residents if fewer than 5 weekly for 4 weeks and monthly for 2 months beginning the week of 9/7/26 to ensure oxygen tubing and nebulizer equipment has been changed and dated per facility policy. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0695 SS = D	Continued from page 62 use. During an interview on 7/30/26 at 11:54 a.m., licensed practical nurse (LPN)-B stated they usually changed the bubbler and tubing when it appeared on the treatment administration record (TAR). LPN-B reviewed R7's orders and didn't find one to change the bubbler and tubing. LPN-B confirmed R7's bubbler was dated 4/2/26 and she didn't see a date on the tubing as to when it was changed. LPN-B stated it was important to do for sanitary reasons. A policy, Oxygen dated 9/23/25, identified all licensed nurses were trained in the use of oxygen and shall be responsible for its administration shall be on duty the entire time oxygen was administered. Under the Miscellaneous category, item number one identified tubing and cannula or mask should be labeled with dated and changed every week.			F0695			09/14/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			F0880	F880 – Infection Prevention and Control – SS=D R2 no longer resides at the facility. R1 transmission-based/enhanced barrier precaution needs were reviewed and appropriate signage and PPE supplies were verified. Staff involved in the cited observations were re-educated regarding required PPE and hand hygiene. Laundry practices were reviewed and wet linen was handled in a manner that prevents microbial growth and contamination. All residents who are on Enhanced Barrier Precautions, Transmission Based Precautions, or received laundry services at the facility have potential to be impacted by this deficient practice. All residents requiring Enhanced Barrier Precautions or Transmission-Based Precautions were reviewed to verify correct precautions, signage, PPE availability, and staff implementation. Laundry practices were also reviewed for appropriate handling of wet linen. DON reviewed the Transmission Based Precautions and Enhanced Barrier Precautions policies with no changes needed. All staff were educated by the DON/designee on the Transmission Based Precautions and Enhanced Barrier Precautions, regarding appropriate PPE selection and use and hand hygiene. Staff whose duties require PPE use will demonstrate competency with donning and		09/14/2026

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F0880 SS = D	Continued from page 63 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff consistently used personal protective equipment (PPE) in resident rooms where precautions were in place to help prevent the spread of bacteria and potential for illness for 2 of 4 residents (R1, R2) reviewed for infection control. This deficient practice had the potential to cause illness for residents, staff, and			F0880	Continued from page 63 doffing. Administrator reviewed the Linen Handling policy and revised to address safe management of wet linen. Administrator/designee will educate the housekeeping staff on the Linen Handling policy, regarding handling of wet linens to prevent microbial growth. The Infection Preventionist/designee will conduct 3 infection-control observations weekly for 4 weeks and monthly for 2 months, including PPE, hand hygiene, isolation/precaution practices beginning the week of 9/7/26. Environmental Services Director will conduct 3 infection-control observations weekly for 4 weeks and monthly for 2 months, for proper handling of wet linen, beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as indicated. Completion Date: 9/14/26		09/14/2026

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F0880 SS = D	Continued from page 64 visitors. In addition, the facility failed to ensure hygienic laundry practices to help minimize potential for bacteria growth. Findings include: R1: R1’s quarterly Minimum Data Set (MDS) dated 7/13/26, identified R1 was cognitively intact. R1’s diagnoses included chronic kidney disease, heart failure, hypertension, diabetes mellitus, anxiety, depression, and sleep apnea. R1's care plan dated 7/28/26, identified R1 was on enhanced barrier precautions (EBP) related to a history of Extended-Spectrum Beta-Lactamase (ESBL) infection in their urine and directed staff to follow EBP. R1’s orders included Enhanced Barrier Precautions due to history a of ESBL dated 4/29/26. During an observation on 7/29/26 at 9:57 a.m., R1's door had a sign indicating R1 was on EBP. The sign instructed staff to wear gowns and gloves for high-contact resident care activities, including changing linens and providing wound care. Licensed practical nurse (LPN)-D and nursing assistant (NA)-A entered R1’s room, without wearing gowns. LPN-D removed R1’s bilateral lower leg stockings, removed dressings from R1’s left shin and right toes, provided wound care, and redressed R1’s wounds. LPN-D wore gloves and changed them appropriately, but they did not wear a gown during the wound care. At the same time, NA-A stripped R1's bed, bagged the soiled linens, and remade R1’s bed with fresh linens with gloved hands but no gown. During an interview on 7/29/26 at 10:08 a.m., NA-A confirmed they had not gowned when entering R1's room. NA-A stated they should have worn a gown when changing R1’s bed linens to keep bacteria from getting on their clothes and potentially spreading to other rooms. During an interview on 7/29/26 at 10:12 a.m., LPN-D confirmed they had not gowned when entering R1’s room. LPN-D stated R1 did not have an active infection. After reviewing R1’s electronic medical record, LPN-D confirmed R1 was on EBP and stated they should have worn a gown for the wound care.			F0880			09/14/2026

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F0880 SS = D	Continued from page 65 During an interview on 7/30/26 at 11:30 a.m., the director of nursing (DON) stated they expected staff to wear the correct personal protective equipment (PPE) when assisting residents on EBP. The DON stated staff should be wearing gowns and gloves when handling bedding and doing dressing changes for residents on EBP. They stated PPE was important to protect themselves and to prevent at-risk residents from potential infection. Facility provided Enhanced Barrier Precautions sign instructed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care. R2: R2’s significant change in status assessment (SCSA) minimum data set (MDS) dated 6/22/26, identified intact cognition and a diagnosis of clostridium difficile (an intestinal infection which can spread through contact with fecal matter, contaminated surfaces with spores. Alcohol-based hand sanitizer is not effective against spores. Special precautions, called enteric precautions must be put in place to include washing hands with soap and water and wiping environmental surfaces with a bleach-based product.) R2 was frequently incontinent of bowels and needed supervision or touch assistance with toilet transfers and hygiene. R2’s care plan dated 6/6/26, identified a focus statement for self-care performance deficits and included interventions to provide limited assistance with toilet transfers and to assist with perineal care every shift and as needed. An additional focus statement for diarrhea related to c. difficile with interventions for contact precautions, but without necessary interventions for enteric precautions. R2’s provider orders didn’t contain orders for contact precautions. During an interview on 7/28/26 at 12:31 p.m., housekeeper (HK)-B stated they had infection prevention training on the computer at hire and in January every year. HK-B stated they didn’t have to demonstrate to anyone how she would put on and take off her PPE. During an observation on 7/28/26 at 2:56 p.m., nursing assistant (NA)-C entered R2’s room without			F0880			09/14/2026

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F0880 SS = D	Continued from page 66 isolation gown or gloves, carried an iPad, talked with R2 and took his meal order. NA-C exited the room without cleaning their hands and continued down the hall to other resident rooms. During an observation on 7/28/26 at 3:19 p.m., HK-A was observed entering R2's room without an isolation gown, but with gloves, and came back out with two yellow plastic trash bags and put them on top of the dumpster she was pushing. HK-A wasn't observed cleaning her hands after exiting the room. Laundry: During an interview on 7/29/26 at 8:22 a.m., during a tour of the laundry facilities with the environmental services director (EVS)-H, laundry aid (LA)-C stated they didn't leave the washer running at the end of the shift. LA-C stated they would place the wet items in the blue bins, designated for wet items, and then cover with a sheet or something and dry it in the morning. During an interview on 7/29/26 at 2:30 p.m., HK-A stated she received infection control training from watching videos every year. HK-A stated she did see the sign outside R2's room and put gloves on because she was just going in to collect the trash. During an interview on 7/29/26 at 9:59 a.m., registered nurse (RN)-G, who identified as the facility's Infection Prevention nurse, stated she would expect housekeeping to wear PPE when in the contact precautions rooms, and same for the NA going in to take a meal order, nor for wet laundry to be left to be dried the next day. RN-G added the housekeeping staff were trained for infection control through EduCare (an internet-based education program) and didn't require return demonstrations for PPE use. During an interview on 7/30/26 at 1:12 p.m., EVS-H stated he used the paperwork from previous people in his position to train new housekeeping staff for infection control. EVS-H stated he would do this on hire before the person goes to the floor and stated he didn't ask them to demonstrate PPE use. EVS-H stated he would expect them to follow procedures for the precautions rooms no matter how long they are in there for. A policy, Transmission-Based Precautions dated 6/16/26, identified its purpose was to provide direction to staff related to transmission-based precautions in the prevention of infections. Contact precautions would be implemented for residents			F0880			09/14/2026

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F0880 SS = D	Continued from page 67 known or suspected of being infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. The policy didn't address expectations for staff usage of PPE or enteric precautions necessary for infections like c. difficile. A policy, Linen Handling dated 3/10/26, identified its purpose was to provide clear and consistent guidelines for the safe handling of linen to protect residents, staff, and the environment from infection and occupational exposure. The policy didn't address handling wet linen.			F0880			09/14/2026

Minnesota Department of Health

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20000	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 7/27 to 7/31/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: NO licensing orders were issued.			20000			09/03/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 H52453370C (3095651) H52453513C (1144338) H52452926C (3043780) H52453512C (1144334) H52453510C (2609673) H52453509C (2611990) H52453508C (2702821) H52453511C (2583675) The following complaints were reviewed with a licensing order issued: H52453478C (3096833) with deficiencies cited at 21880 H52452897C (3041640) with deficiencies cited at 20830 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 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 heading completion date, the date your orders will be corrected prior to			20000			09/03/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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20000	Continued from page 2 electronically submitting to the Minnesota Department of Health. 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.			20000			09/03/2026
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the minimum data sets (MDS) was completed accurately and timely for 1 of 3 residents (R25) reviewed for activities of daily living, and 1 of 4 residents (R69) reviewed for quality of care and 1 of 1 resident (R43) for oral/dental. Findings include: R25: Per the Centers for Medicare and Medicaid Services (CMS) and the resident assessment instructions (RAI) manual, a significant change in assessment (SCSA) must be completed less by the end of the 14th day following determination that a significant change has occurred or 14 days after the assessment reference date (ARD). R25's SCSA MDS with an ARD of 4/9/26, identified moderately impaired cognition and diagnoses of malignant neoplasm of lung, and secondary neoplasm of bone. The RN assessment coordinator signed as complete on 4/28/26. Section GG for functional limitation in range of motion was not assessed. During an interview on 7/30/26 at 11:24 a.m., registered nurse (RN)-H, who identified as the MDS coordinator, stated there wasn't date from the nursing staff to be able to code section GG of the			20550	Corrected		09/14/2026

Minnesota Department of Health

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20550	Continued from page 3 MDS. RN-H stated it would be important for section GG to be completed to know the resident's baseline and for billing purposes. R69: R69's admission Minimum Data Set (MDS) dated 8/13/25, identified section C cognitive patterns, section D mood had not been assessed. Section E behavior was missing assessments. During an interview on 7/29/26 at 1:25 p.m., registered nurse (RN)-H reviewed R69's admission MDS and verified sections C, D, and E were missing information. RN-H stated social services would usually complete sections C, D, and E. RN-H verified it was important to have all sections completed for a baseline assessment so they could compare them at the next assessment. R43: R43's quarterly MDS dated 7/20/26, identified section L oral/dental, was not completed (it was left with dashes). During an interview on 7/29/26 at 1:27 p.m., RN-H reviewed R43's MDS and verified section L was missing information. RN-H stated it should have been completed and stated it would be important to have the information so any changes could be reviewed at the next assessment. During an interview on 7/30/26 at 11:59 a.m., the director of nursing (DON) verified the MDS assessments needed to be completed for coding, billing, and to develop the residents care plans. MDS 3.0 Assessment dated 8/20/24, identified all MDS assessments and Discharge and Reentry records would be completed following the Resident Assessment Instrument (RAI) instructions. The RAI further identified all items should be completed and signed within the required time frames according to the RAI Manual. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's MDS were completed accurately and timely. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.			20550			09/14/2026

Minnesota Department of Health

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20550	Continued from page 4 The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550			09/14/2026	
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to include dialysis to a resident's comprehensive care plan, who received dialysis while in the facility. This affected 1 of 1 (R2) residents reviewed for comprehensive care plans. Findings include: R2's quarterly Minimum Data Set (MDS) dated 7/10/26, indicated R2 was cognitively intact. Diagnoses included anemia, hypertension, and end stage renal disease. Section O: Special Treatments, Procedures, and Programs indicated R2 received dialysis while at the facility. R2's Active Order Summary Report dated 7/30/26, indicated an order to monitor perma-catheter site for pain, swelling, or signs of infection. The order summary report lacked orders related to R2's dialysis. R2's care plan lacked a care plan related to R2's dialysis and interventions to treat the dialysis, until a care plan was initiated on 7/28/26. During an interview on 7/28/26 at 12:49 p.m., R2 stated dialysis was received through the dialysis center in Hibbing, Mn on Tuesday, Thursday, and Saturday. Dialysis was received through the perma-catheter in the right chest wall.		20555	Corrected		09/14/2026	

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20555	Continued from page 5 During an interview on 7/30/26 at 9:06 p.m., the licensed practical nurse (LPN)-A stated all resident specific medical conditions such as heart conditions, respiratory conditions and kidney conditions, like the need for dialysis, would have their own specific care plans so all staff would be aware of the condition and know how to provide care related to the condition. During an interview on 7/30/26 at 9:29 a.m., registered nurse (RN)-D stated the RN was responsible for building the care plan based on diagnoses and the information in the MDS assessment. RN-D reviewedR2's MDS assessment from 7/10/26, and R2's active care plan and acknowledge the MDS assessment showed R2 received dialysis but there was no active care plan related to the Dialysis is R2's current care plan. During an interview on 7/30/26 at 9:40a.m., the director of nursing (DON) stated all RN's should make sure the comprehensive care plan has all details related to what is on the comprehensive MDS assessment in the resident's active care plan. The facility policy Person Centered Care Planning dated 6/16/26 indicated a comprehensive person-centered are plan would be completed with 7 days of the MDS completion. The care plan would be based on the MDS assessment and care area assessments. The care plan would cover specialized services and include measurable goals and interventions SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure comprehensive care plans are built. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20555			09/14/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary			20570	Corrected		09/14/2026

Minnesota Department of Health

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20570	Continued from page 6 team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to review and revise the care plan to reflect the resident's current needs for 4 of 4 residents (R25, R48, R3, R5) reviewed for care planning. Findings include: R25: R25's quarterly minimum data set (MDS) dated 7/7/26, identified severely impaired cognition and diagnoses of diabetes mellitus, malignant neoplasm of the lung, and secondary malignant neoplasm of the bone. R25 needed set-up assistance for eating, maximum assistance with toilet hygiene, and dressing the lower body. The MDS also indicated R25 was occasionally incontinent of urine and always incontinent of bowel. R25's care plan dated 6/12/25 identified a focus statement for activities of daily living (ADL)s self-care performance deficit and included interventions for partial to moderate assist with showers, R25 able to complete upper, lower body and footwear independently, and was independent with eating, personal hygiene and oral care. R25 needed to be offered to bring to the toilet every two hours and as needed due to bladder incontinence. The care plan further identified R25 was alert and oriented to person, place, and time with intermittent confusion. BIMS (cognitive score) indicated moderate cognitive impairment. During an interview on 7/30/26 at 11:24 a.m., registered nurse (RN)-H, who identified as the MDS coordinator, stated there wasn't enough change in R25's quarterly MDS (compared with a significant change MDS of 4/9/26) from her baseline to be a significant change again. RN-H stated care planning was done by the nurses when they did the assessments, they will update the care plan and			20570			09/14/2026

Minnesota Department of Health

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20570	Continued from page 7 RN-H added once she was fully running, she would be updating the care plans. During an interview on 7/30/26 at 11:52 a.m., RN-E, who identified as the charge nurse, stated she was given a list of what assessments were due and when, and then she along with the other charge nurses would update the care plan. RN-E stated an up-to-date care plan would be important to be able to care for the residents safely and properly. R48: R48's quarterly MDS dated 6/24/26, identified intact cognition and diagnoses of encephalopathy, aphasia, spondylosis of the thoracic, lumbar and cervical regions. R48 was independent with eating and needed set-up oral care. R48 needed maximum assist with showers, personal and toilet hygiene, transfers, and bed mobility, and was dependent for toilet hygiene with occasional bowel incontinence. R48's care plan dated 3/27/26, identified a focus statement for an ADL self-care performance deficit and included interventions for total dependence and assist of two staff for bathing, transferring with non-mechanical standing lift and assist of two staff and if he was unable to stand with that then use the mechanical sling lift. R48's care plan also included a focus statement for requiring g-tube feedings due to dysphagia (difficulty swallowing) with interventions to administer feedings as ordered but may have ice chips with supervision. R48 had bowel incontinence related to immobility and interventions for staff to check every two hours and assist with toilet and provide peri care PRN. R48's therapy orders included a memo on the inside of his closet door dated 7/23/26, for R48 to use a stand pivot transfer using a gait belt and contact guard assist of one. During an interview on 7/27/26 at 5:10 p.m., R48 was eating his dinner in his room and stated he didn't use his feeding tube anymore, just for one of his medications. During an interview on 7/28/26 at 3:23 p.m., nursing assistant (NA)-D stated she knew how to transfer R48 because of the posting from therapy in his closet. NA-D also stated R48 used the toilet, not a bed pan as the care plan indicated. During an interview on 7/28/26 at 3:27 p.m., RN-E, who identified as a charge nurse, stated if something needed to be updated to the care plan			20570			09/14/2026

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20570	Continued from page 8 she would just do it but thinks the MDS nurse also has a part in it. During an interview on 7/29/26 at 1:56 p.m., the therapy director (TD)-I stated once they established the plan of care through evaluation, they write a care plan for transfer and level of assist, or walking program or whatever applied. TD-I stated they then put that care plan in the resident's room in their cabinet door and gave a copy to the director of nursing (DON) and nurse managers, and on a weekly basis he presents a weekly update to DON, MDS coordinator, nurse managers and department heads. A policy, Person Centered Care Planning dated 6/16/26, identified its purpose was to provide guidance to care center staff on developing and establishing the resident's person-centered care plan. Person-centered care planning identifies each resident's individualized strengths, needs, preferences, supports, and goals to guide care and services. Care plans must include measurable goals and timeframes based on the comprehensive assessment. If the comprehensive assessment identifies changes in goals, interventions, or functioning that were not identified in the baseline care plan, those changes will be communicated to the resident and/or representative, with an updated care plan provided. The comprehensive care plan will be reviewed and revised quarterly, upon significant change in condition, or as otherwise necessary to reflect the resident's current needs, goals, and preferences. R3: R3's quarterly Minimum Data Set (MDS) dated 6/29/26, identified R3 had diagnoses which included hemiplegia/hemiparesis (complete or severe paralysis on one side of the body/mild to moderate weakness on one side of the body), dysphagia (difficulty or discomfort when swallowing foods, liquids, or even saliva), hyperlipidemia, aphasia (a brain disorder that affects how one speaks, reads, writes, and understanding what other people say), hypertension. In addition, R3's MDS identified she had unclear speech, was severely cognitively impaired, and was dependent on staff for activities of daily living. R3's care plan reviewed on 7/28/26, (care plan was requested but not provided) did not identify that R3 did not want male care givers. R3's progress note dated 3/8/26, identified no males for personal cares.			20570			09/14/2026

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20570	Continued from page 9 During an interview on 7/29/26 at 1:42 p.m., nursing assistant (NA)-G stated it was only “word of mouth” that R3 only wanted female care givers for personal cares. NA-G verified there was nothing on the care guides to indicate she only wanted female care givers. During an interview on 7/29/26 at 1:44 p.m., licensed practical nurse (LPN)-A verified the care plan did not identify R3 preferred only female care givers. During an interview on 7/30/26 at 12:29 p.m., the director of nursing (DON) stated she was aware R3 did not want any male care givers. The DON verified this information should have been part of her care plan. R5: R5’s admission MDS dated 5/13/25, identified she had diagnoses which included dementia, heart failure (the heart muscle does not pump blood as well as it should), diabetes mellitus, depression, hyperlipidemia, and heart disease. In addition, R5’s MDS identified she was moderately cognitively intact, required supervision with eating and partial to moderate assistance with activities of daily living. A review of R5’s care plan on 7/28/26, identified R5’s care plan did not identify she needed to be out of bed for meals. A progress note dated 7/6/26 written at 1:59 p.m., identified therapy reported increased confusion and weakness when sitting at the bedside. The note identified she was unable to hold herself up. The note identified she was also spilling food when eating in bed. Therapy recommended they would like her to be up in her chair for meals. During an observation on 7/28/26 at 12:10 p.m., R5 was observed lying in her bed eating her lunch. During an observation on 7/29/26 at 8:37 a.m., R5 was observed lying in bed eating breakfast. During an interview on 7/29/26 at 1:39 p.m., nursing assistant (NA)-G and licensed practical nurse (LPN)-A both stated they were not aware R5 was supposed to be out of bed for meals. They were unsure how therapy communicated the information for R5 to be in her chair for meals. LPN-A verified the information was in the progress notes but the care plan had not been updated with the information.			20570			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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20570	Continued from page 10 During an interview on 7/30/26 at 10:52 a.m., therapy director (PTA)-A stated staff in the therapy department would write a care plan for the resident to identify the resident needed to be up for meals, that information would go to the nurse manager and the DON and then the information would get put into the resident's closet. PTA-A reviewed the notes and identified nursing had been informed of the change but that a care plan change had not been made. PTA-A stated therapy would be responsible for making the changes and posting the changes in the closet. During an interview on 7/30/26 at 12:14 p.m., the DON stated she would expect nursing to get R5 up for meals per therapy's recommendation and make this part of her care plan. She would expect staff to continue to evaluate R5's care and update the care plan as needed. Person Centered Care Planning dated 4/20/23, identified the facility would develop a comprehensive person-centered care plan with the resident and/or family representative for each resident. In addition, the care plan would be reviewed every 90 days or more frequently, if necessary, based on changes that occurred between care conferences. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans created are revised with resident specific interventions to identify all known target behaviors and interventions used to identify health care needs and diagnosed conditions. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure care plans are individualized, used, and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20570			09/14/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and		20830	Corrected		09/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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20830	Continued from page 11 preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe ambulation interventions were followed for 2 of 2 residents (R14, R75) reviewed. In addition, the facility failed to ensure resident equipment concerns were addressed in a timely manner to help prevent accidents for 1 of 5 residents (R9) reviewed for accident and safety concerns. Findings include: R14: R14's significant change Minimum Data Set (MDS) dated 7/3/26, identified R14 was severely cognitively impaired. R14's diagnoses included acute on chronic congestive heart failure, acute on chronic respiratory failure with hypoxia, hypertension, atrial fibrillation, difficulties in walking, abnormalities of gait and mobility, and weakness. R14's care plan revised 2/4/26 indicated that R14 required supervision with touching assist of 1 staff for ambulating with front wheeled walker (FWW). R14's physical therapy (PT) treatment encounter notes dated 6/10/26, identified R14 was doing gait training with stand by assist (SBA) without an assistive device, R14 ambulated 150 feet, and sustained a fall as R14's legs could not keep up with the rest of their body. R14's Incident Report Form dated 6/10/26 identified a fall in the hallway near the nurse's station on 6/10/26 at 4:15 p.m. R14 was gait training with therapy staff assist of 1. No assistive device or gait belt was identified in the report. R14's Emergency Room (ER) encounter summary dated 6/11/26 indicated R14 had an acute anterior left third rib fracture. R14 had refused to go to the ER at the time of the fall on 6/10/26.			20830			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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20830	Continued from page 12 R14's physician encounter note dated 6/15/26 evaluated R14's fracture of left rib following a fall on 6/10/26 and indicated no new orders related to the rib fracture. During an interview on 7/29/26 at 1:34 p.m., the DON stated they were a charge nurse at the time of R14's fall incident on 6/10/26. They observed R14 ambulating past the nurse's station with therapy staff on 6/10/26, heard a crash, and ran into the hallway. R14 was lying in the middle of the hallway, 1 therapy staff was present, R14 had no gait belt and no FWW. During an interview on 7/29/26 at 2:02 p.m., physical therapy assistant (PTA)-A stated that the rehabilitation department's policy was to use a gait belt with any type of transfer or ambulation. PTA-A stated if a resident refused the use of a gait belt, they would explain the risks and benefits of its use, and if a resident continued to refuse, they would not do gait training without a gait belt. PTA-A stated gait belts were an important safety intervention to provide stability and reduce falls. On 7/29/26 at 9:21 a.m., attempted to call the physical therapy assistant that was ambulating the resident at the time of R14's fall on 6/10/26. A voicemail was left but the call was not returned. R75: R75's 5-day Minimum Data Set (MDS) dated 7/17/26, identified R75 was cognitively intact. R75's diagnoses included fracture of left clavicle, fracture of sternum, and hypertension. R75's care plan revised 7/22/26, identified that R75 was able to ambulate independently with a front wheeled walker (FWW) in their resident room. The care plan did not include instructions for ambulating outside the resident room and it did not include physical therapy (PT) orders. R75's physician orders dated 7/10/26, instructed Physical Therapy Evaluate and Treat as Indicated. R75's PT orders signed 7/22/26, instructed staff to walk R75 with gait belt, FWW, and stand by assist – contact guard assist (SBA-CGA) of 1 to lunch and supper in dining room daily. These orders were observed on the inside of R75's closet door on 7/29/26 at 12:28 p.m. During an observation on 7/29/26 at 12:01 p.m., R75			20830			09/14/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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20830	Continued from page 13 ambulated independently into the hallway with their FWW. The activities director (AD) met R75 in the hallway and asked where R75 was going. R75 stated they were headed to lunch, but they were not supposed to walk in the hallway alone. AD walked with R75 to the dining area with the FWW but no gait belt. During an observation on 7/29/26 at 12:27 p.m., nursing assistant (NA)-A walked with R75 from the dining table to R75's room with the FWW but no gait belt. During an interview on 7/29/26 at 12:28 p.m., NA-A stated R75 ambulated independently in their room but NA-A was not sure if staff were to use a gait belt when walking with R75 outside the resident's room. NA-A stated PT orders were posted inside resident closet doors, and a copy was kept at the nurse's station. After reviewing R75's PT orders on R75's closet door, NA-A confirmed R75 was SBA of 1 with a FWW and gait belt. NA-A stated they usually use a gait belt when walking with residents to reduce the risk of falls. During an interview on 7/29/26 at 12:34 p.m., the AD stated they forgot to use a gait belt when walking with R75 to the dining area. AD stated gait belts were important to keep hands on residents while walking to help steady them. During an interview on 7/29/26 at 2:09 p.m., physical therapy assistant (PTA)-A stated that each resident had a gait belt on a hook near their resident door. PTA-A expected staff to use a gait belt every time they were walking with a resident. During an interview on 7/29/26 at 1:34 p.m., the director of nursing (DON) stated they expected staff to use safety interventions when ambulating residents including gait belts. They stated a gait belt was important because it allows staff to give more stability to the residents and potentially reduce injury by slowing and controlling a fall. Transfer Belts policy, undated, instructed a transfer belt was to be used when transferring or ambulating any resident who required staff assistance. R9: On 7/27/26 at 2:27 p.m., R9 stated she fell last Saturday night (7/18/26) next to the bed because when she went to get into it the brakes on her wheelchair wouldn't lock and it rolled away. R9 stated maintenance was aware, and nursing staff had left notes and emailed the maintenance guy, but it hadn't gotten fixed. R9 added a male nursing			20830			09/14/2026

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20830	Continued from page 14 assistant had fixed the wheelchair brake for her after she fell but it had gone bad again and wasn't working at this time. R9 was trying to demonstrate locking her right brake. During an interview on 7/29/26 at 1:08 p.m., NA-B stated R9 had complained about her wheelchair brakes prior to when she fell that Saturday. NA-B didn't recall if or when she put a work order in. During an interview on 7/30/26 at 1:06 p.m., environmental services director (EVS)-H stated he wanted work orders to come strictly from the maintenance app, but some people would leave notes, or tell him when they saw him, so he redirects them to put it on the app. EVS-H stated he prioritized work by resident things if it was affecting the resident or their equipment. EVS-H didn't recall the first time he heard about R9's wheelchair brakes; he heard there were staff who told R9 they put tickets in, but a request wasn't put in until Saturday the 18th and he went that Monday to check on it on and it was working ok at that time. EVS-H added R9 had come to the administrator on the evening of 7/27/26 about her wheelchair, and when EVS-H looked at it he decided to just replace the whole wheelchair. A policy, Resident Concerns dated 1/17/19, identified its purpose was to provide guidelines to staff for following up on resident or representative concerns. Resident concerns related to personal belongings, resident room, equipment, missing items, behaviors, etc. will be reported to the social services department, determined if it was a reportable incident, document on a concern form or other designated place in the medical record and routed to the appropriate department head who will document their follow up and return to social services. Environmental concerns would be reported to the maintenance department on a maintenance slip, logged by maintenance and followed up and documented by maintenance as completed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analysis of falls occurs for fall prevention. The DON or designee should educate staff and conduct measurable audits of fall to ensure analysis of the root cause is completed, and ensure identified interventions are in place to prevent falls. The DON or designee should ensure the results of those audits are taken to QAPI to determine compliance or the need for ongoing monitoring.			20830			09/14/2026

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20830	Continued from page 15		20830			09/14/2026	
20875	TIMEFRAME FOR CORRECTION: Twenty-One (21) days. Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure orders were followed as written for 1 of 1 resident (R28) reviewed for quality of care. Findings include: R28's quarterly Minimum Data Set (MDS) dated 7/10/26, identified R28 had diagnoses which included multiple sclerosis (a long-lasting disease of the brain and spinal cord), diabetes mellitus, persistent atrial fibrillation (a common irregular heart rhythm where the upper heart chamber beats fast and out of sync with the lower chambers), hypertension, hyperlipidemia, heart failure (a chronic condition where the heart muscle cannot pump blood and oxygen well enough to meet the body's needs). In addition, R28's MDS identified he was cognitively intact and was dependent on staff for assistance with activities of daily living. During an interview on 7/30/26 at 4:24 p.m., family member (FM)-N expressed concerns about therapies not being continued since the new physical therapy department started. FM-N stated they had talked with the facility about her concerns with lack of therapy. FM-N thought R28's provider had re-ordered the therapy, but he was not receiving any treatment. A physician's update with a date of 7/3/26, identified a family requested an order for the resident to receive lymphedema treatment. The provider responded on 7/7/26, "ok for occupational therapy referral for lymphedema treatments." A review of R28's current orders on 7/30/26, (requested but not provided) identified there were no orders for lymphedema massage.		20875	Corrected		09/14/2026	

Minnesota Department of Health

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20875	Continued from page 16 During an interview on 7/31/26 at 8:24 a.m., therapy director (PTA)-A stated R28 had been getting treatment for lymphedema therapy up until May 2026, when the facility changed to a different therapy company. PTA-A stated their department had not received any orders for lymphedema therapy for R28. During an interview on 7/31/26 at 8:42 a.m., registered nurse (RN)-E confirmed the order for lymphedema order had been signed off on 7/7/26. During an interview on 7/31/26 at 10:08 a.m., the director of nursing (DON) verified when nursing received a provider order, the order should be entered as an order and not as a progress note. The DON stated if an order is entered as a progress note instead of an order the order will not be carried out. During an interview on 7/31/26 at 10:24 a.m., nurse practitioner (NP)-F stated R28 would probably benefit from lymphedema treatment. NP-F stated she would expect orders to be processed as written. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure orders are followed as written. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20875			09/14/2026
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			20930	Corrected		09/14/2026

Minnesota Department of Health

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20930	Continued from page 17 nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure the tube feeding bottle was dated and timed when opened for 1 of 1 resident (R3) reviewed for tube feeding cares. Findings include: R3's quarterly Minimum Data Set (MDS) dated 6/29/26, identified R3 had diagnoses which included hemiplegia/hemiparesis (complete or severe paralysis on one side of the body/mild to moderate weakness on one side of the body), dysphagia (difficulty or discomfort when swallowing foods, liquids, or even saliva), hyperlipidemia, aphasia (a brain disorder that affects how one speaks, reads, writes, and understanding what other people say), hypertension. In addition, R3's MDS identified she had unclear speech, was severely cognitively impaired, and was dependent on staff for activities of daily living. R3's MDS also identified R3 received tube feedings. R3's current physician's orders reviewed on 7/28/26, identified she had orders for nocturnal feedings Jevity 1.5 at 83 milliliters (ml) per hour from 7:00 p.m. to 7:00 a.m.. The orders were requested but not provided. During an observation on 7/29/26 at 7:15 a.m., R3 was resting in bed with the head of the bed at approximately 30 degrees, Jevity 1.5 was running at 83 ml per hour on a pump. The bottle had no open date or time and the tubing was not dated. During an interview on 7/29/26 at 7:53 a.m., licensed practical nurse (LPN)-A verified the tube feeding bottle was not dated or timed when opened. LPN-A also verified the tubing was undated. LPN-A stated it should be dated and timed to ensure the tube feeding doesn't hang longer than it should. During an interview on 7/30/26 at 12:29 p.m., the director of nursing (DON) stated it was her expectation that staff would date, time, and initial the tube feeding bottle and tubing to ensure the tube feeding didn't hang too long. A policy on tube feedings was requested but not provided.			20930			09/14/2026

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20930	Continued from page 18 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff dated and timed the tube feeding bottle and tubing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20930			09/14/2026	
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff consistently used personal protective equipment (PPE) in resident rooms where precautions were in place to help prevent the spread of bacteria and potential for illness for 2 of 4 residents (R1, R2) reviewed for infection control. This deficient practice had the potential to cause illness for residents, staff, and visitors. In addition, the facility failed to ensure hygienic laundry practices to help minimize potential for bacteria growth. Findings include: R1:R1's quarterly Minimum Data Set (MDS) dated 7/13/26, identified R1 was cognitively intact. R1's diagnoses included chronic kidney disease, heart failure, hypertension, diabetes mellitus, anxiety, depression, and sleep apnea. R1's care plan dated 7/28/26, identified R1 was on enhanced barrier precautions (EBP) related to a history of Extended-Spectrum Beta-Lactamase (ESBL) infection in their urine and directed staff to follow EBP.		21385	Corrected		09/14/2026	

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21385	Continued from page 19 R1’s orders included Enhanced Barrier Precautions due to history a of ESBL dated 4/29/26. During an observation on 7/29/26 at 9:57 a.m., R1's door had a sign indicating R1 was on EBP. The sign instructed staff to wear gowns and gloves for high-contact resident care activities, including changing linens and providing wound care. Licensed practical nurse (LPN)-D and nursing assistant (NA)-A entered R1’s room, without wearing gowns. LPN-D removed R1’s bilateral lower leg stockings, removed dressings from R1’s left shin and right toes, provided wound care, and redressed R1’s wounds. LPN-D wore gloves and changed them appropriately, but they did not wear a gown during the wound care. At the same time, NA-A stripped R1’s bed, bagged the soiled linens, and remade R1’s bed with fresh linens with gloved hands but no gown. During an interview on 7/29/26 at 10:08 a.m., NA-A confirmed they had not gowned when entering R1’s room. NA-A stated they should have worn a gown when changing R1’s bed linens to keep bacteria from getting on their clothes and potentially spreading to other rooms. During an interview on 7/29/26 at 10:12 a.m., LPN-D confirmed they had not gowned when entering R1’s room. LPN-D stated R1 did not have an active infection. After reviewing R1’s electronic medical record, LPN-D confirmed R1 was on EBP and stated they should have worn a gown for the wound care. During an interview on 7/30/26 at 11:30 a.m., the director of nursing (DON) stated they expected staff to wear the correct personal protective equipment (PPE) when assisting residents on EBP. The DON stated staff should be wearing gowns and gloves when handling bedding and doing dressing changes for residents on EBP. They stated PPE was important to protect themselves and to prevent at-risk residents from potential infection. Facility provided Enhanced Barrier Precautions sign instructed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care. R2: R2’s significant change in status assessment (SCSA) minimum data set (MDS) dated 6/22/26, identified			21385			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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21385	Continued from page 20 intact cognition and a diagnosis of clostridium difficile (an intestinal infection which can spread through contact with fecal matter, contaminated surfaces with spores. Alcohol-based hand sanitizer is not effective against spores. Special precautions, called enteric precautions must be put in place to include washing hands with soap and water and wiping environmental surfaces with a bleach-based product.) R2 was frequently incontinent of bowels and needed supervision or touch assistance with toilet transfers and hygiene. R2’s care plan dated 6/6/26, identified a focus statement for self-care performance deficits and included interventions to provide limited assistance with toilet transfers and to assist with perineal care every shift and as needed. An additional focus statement for diarrhea related to c. difficile with interventions for contact precautions, but without necessary interventions for enteric precautions. R2’s provider orders didn’t contain orders for contact precautions. During an interview on 7/28/26 at 12:31 p.m., housekeeper (HK)-B stated they had infection prevention training on the computer at hire and in January every year. HK-B stated they didn’t have to demonstrate to anyone how she would put on and take off her PPE. During an observation on 7/28/26 at 2:56 p.m., nursing assistant (NA)-C entered R2’s room without isolation gown or gloves, carried an iPad, talked with R2 and took his meal order. NA-C exited the room without cleaning their hands and continued down the hall to other resident rooms. During an observation on 7/28/26 at 3:19 p.m., HK-A was observed entering R2’s room without an isolation gown, but with gloves, and came back out with two yellow plastic trash bags and put them on top of the dumpster she was pushing. HK-A wasn’t observed cleaning her hands after exiting the room. Laundry: During an interview on 7/29/26 at 8:22 a.m., during a tour of the laundry facilities with the environmental services director (EVS)-H, laundry aid (LA)-C stated they didn’t leave the washer running at the end of the shift. LA-C stated they would place the wet items in the blue bins, designated for wet items, and then cover with a sheet or something and dry it in the morning.			21385			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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21385	Continued from page 21 During an interview on 7/29/26 at 2:30 p.m., HK-A stated she received infection control training from watching videos every year. HK-A stated she did see the sign outside R2’s room and put gloves on because she was just going in to collect the trash. During an interview on 7/29/26 at 9:59 a.m., registered nurse (RN)-G, who identified as the facility’s Infection Prevention nurse, stated she would expect housekeeping to wear PPE when in the contact precautions rooms, and same for the NA going in to take a meal order, nor for wet laundry to be left to be dried the next day. RN-G added the housekeeping staff were trained for infection control through EduCare (an internet-based education program) and didn’t require return demonstrations for PPE use. During an interview on 7/30/26 at 1:12 p.m., EVS-H stated he used the paperwork from previous people in his position to train new housekeeping staff for infection control. EVS-H stated he would do this on hire before the person goes to the floor and stated he didn’t ask them to demonstrate PPE use. EVS-H stated he would expect them to follow procedures for the precautions rooms no matter how long they are in there for. A policy, Transmission-Based Precautions dated 6/16/26, identified its purpose was to provide direction to staff related to transmission-based precautions in the prevention of infections. Contact precautions would be implemented for residents known or suspected of being infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident’s environment. The policy didn’t address expectations for staff usage of PPE or enteric precautions necessary for infections like c. difficile. A policy, Linen Handling dated 3/10/26, identified its purpose was to provide clear and consistent guidelines for the safe handling of linen to protect residents, staff, and the environment from infection and occupational exposure. The policy didn't address handling wet linen. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the			21385			09/14/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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21385	Continued from page 22 policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21385			09/14/2026	
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete a tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings for 2026. In addition, the facility failed to ensure symptom screening was performed timely and a second tuberculin skin test (TST) was performed for 1 of 5 employees (EE-1) and failed to ensure symptom screening was performed for 4 out of 5 employees (EE-2, EE-3, EE-4, EE-5). Findings include: EE-1's start date was documented 1/14/26, with TB symptom screening performed on 3/3/26, and one TST read on 4/3/26. Documentation for a second TST was not received. EE-2's start date was documented 6/23/26, no TB symptom screening form was received for EE-2. EE-3's start date was documented 4/2/26, no TB symptom screening form was received for EE-3. EE-4's start date was documented 5/12/26, no TB symptom screening form was received for EE-4. EE-5's start date was documented 3/16/26, no TB symptom		21426	Corrected		09/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
21426	Continued from page 23 screening form was received for EE-5. During an interview on 7/29/26 at 9:59 a.m., registered nurse (RN)-G, who identified as the facility's infection control nurse stated she had been filling in for director of nursing (DON) duties for a couple of months and some of her normal things fell through the cracks. Documentation for R3, R14, R48, R52, R54's TB symptom screening and TB testing information was requested but not received. The facility's 2025 TB Risk Assessment identified baseline TB screening of all health care personnel was performed at time of hire as required. The assessment also identified the facility performed baseline TB screening of all patients performed at time of admission as required. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21426			
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to follow a self-administration of medication (SAM) form which indicated the resident should not self-administer medications. This affected 1 of 1 (R54) residents reviewed for self-administration of medications.			21565	Corrected		09/14/2026

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21565	Continued from page 24 Findings include: R54's quarterly Minimum Data Set (MDS) dated 5/21/26, indicated R25 had no cognitive impairment. Diagnoses included anemia, multiple sclerosis, and seizure disorder. R54's Active Order Summary Report dated 7/30/26, lacked orders to keep any medications at bedside. R54's care plan dated 9/3/25, indicated R54 was unable to self-administer medications. Interventions included nursing responsibility to document, administer, and store all medications. R54's Self Administration of Medication (SAM) Evaluation form dated 8/21/25, indicated R54 could not self-administer medications and could not keep medications at bedside. On 7/27/26 at 4:18 p.m., medications including a tube of Diclofenac muscle cream, Biotin mouth wash, and Systane eye drops were observed on R54's bedside table. No staff were in the room. On 7/30/26 at 9:02 a.m., the same medications were again observed on R54's bedside table and there were no staff present. During an interview on 7/30/26 at 9:05 a.m., licensed practical nurse (LPN)-A stated a SAM assessment and orders from the provider to keep at bedside are needed prior to leaving medications at bedside. LPN-A confirmed Diclofenac, Biotin, and Systane were left in R54's room, but was unsure if R54 should have them left at bedside. During an interview on 7/30/26 at 9:29 a.m., registered nurse (RN)- D stated the RN did the SAM assessments. Once completed, the RN would let licensed staff know who could keep medications at bedside. RN-D reviewed R54's SAM assessment and acknowledged R54 should not have medications left at bedside. During an interview on 7/30/26 at 9:40 a.m., the director of nursing (DON) stated an expectation staff would make sure all appropriate paperwork, such as the SAM assessment, were completed and accurate prior to leaving medication at bedside. Facility policy Self-Administration of Medication by Residents last revised 2/27/24, indicated the SAM assessment would be completed and reviewed by the interdepartmental team (IDT). A decision would be made by the IDT prior to keeping medications at			21565			09/14/2026

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21565	Continued from page 25 bedside. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Medications are left at bedside when the Self administration of Medication indicates appropriate. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21565			09/14/2026	
21825	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 9 Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents were informed of and consented to medications prescribed and given for		21825	Corrected		09/14/2026	

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21825	Continued from page 26 mental health intervention for 2 of 5 residents (R7, R33) reviewed for unnecessary medications. In addition, the facility failed to ensure a Provider Order for Life Sustaining (POLST) was signed timely. Findings include:R7: R7’s significant change in assessment (SCSA) minimum data set (MDS) dated 7/6/26, identified intact cognition and diagnoses of Parkinsons, anxiety, insomnia, and bipolar disorder. R7’s care plan dated 4/9/26, identified a focus statement for behavior related to bipolar disorder and anxiety. Interventions include target behaviors, non-pharmacological interventions, to administer medications per order and monitor for side effects. R7’s provider order on 7/21/26, Depakote 250 milligrams (mg) by mouth two times per day for bipolar disorder. And an order on 5/31/26, gabapentin 300 mg by mouth three times per day for anxiety. R7’s electronic medical record (EMR) didn’t contain evidence of R7 having been educated on the risks, benefits, side effects, and alternatives for Depakote or gabapentin which were both treating mental health diagnoses. R33: R33’s significant change Minimum Data Set (MDS) dated 6/9/26, identified R33 had diagnoses which included Parkinson’s disease, polyneuropathy, depression, and anxiety. In addition, R33’s MDS identified he was severely cognitively impaired, was dependent on staff for activities of daily living, and received antianxiety medications, opioids, and anticonvulsants. R33’s Order Summary Report identified he had orders for the following medications: Celexa 20 milligrams (mg) one time a day for major depressive disorder Hydroxyzine 10 mg two times a day for hallucinations/delusions related to Parkinson’s disease Risperidone 0.25 mg at bedtime for hallucinations related to major depressive disorder. A review of R33’s electronic medical record (EMR) identified R33 had a consent for Celexa, but not for			21825			09/14/2026

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21825	Continued from page 27 hydroxyzine or risperidone. During an interview on 7/30/26 at 12:12 p.m., the director of nursing (DON) stated it was important for residents and/or their families to know the side effects and the risk for taking the medication to decide if the risk was worth taking the medication. Psychotropic Medications dated 5/21/25, identified care center nursing staff would review the psychotropic medication informed consent with the resident and/or representative and then would obtain a signature for use of the medication(s). Psychotropic medications were defined as anti-anxiety, hypnotic/sedative, antipsychotic, anticonvulsant, antihistamine, and antidepressant classes of drugs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure consents were obtained for antipsychotic medications and consents for POLSTs were signed timely. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21825			09/14/2026
21880	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.			21880	Corrected		09/14/2026

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21880	Continued from page 28 Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were provided with the current Combined Federal and State Bill of Rights. This had the potential to affect all 62 residents and their representatives who resided in the facility. Findings include: In response to a concern reported in 2026, R26 felt their rights had been violated when they resided in the facility for six days. A review of the facility's admission folder identified they were providing residents with the Combined Federal and State Bill of Rights dated 2/1/17. The most current Federal and State Bill of Rights has a date of 12/22/25. During an interview on 7/30/26 at 12:03 p.m., the director of nursing (DON) stated they did not know how residents received their admission packet. During an interview on 7/30/26 at 12:22 p.m., registered nurse (RN)-I stated residents can receive their admission packet in paper form or electronically. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to			21880			09/14/2026

Minnesota Department of Health

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21880	Continued from page 29 ensure staff provided the most current copy of the Combined Federal and State Bill of Rights. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21880			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/28/2026. At the time of this survey, Heritage Manor Bldg 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:			K0000			09/04/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Heritage Manor is a 1-story building with a partial basement. The original building was constructed in 1953 and was determined to be built of Type II(111) construction. In 1981 and 2001, two additions were constructed to the building and determined to be built of Type II(111) construction. Heritage Manor is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility is divided into smoke compartments and separated from an apartment building by a two-hour fire-rated wall. The facility has a capacity of 65 beds and had a census of 60 at the time of the survey.			K0000			09/04/2026
K0223 SS = F Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area			K0223	K0223: Doors with Self-Closing Devices The double-fire barrier doors at Lake View Wing will be repaired to ensure they close properly and eliminate any gaps between compartments. All double-fire barrier doors will be inspected for proper closure and gaps and corrected if needed.		09/14/2026

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K0223 SS = F Bldg. 01	Continued from page 2 enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026, at 10:45am, it was revealed by observation that the double fire barrier doors located at the Lake View Wing, between two different smoke compartments did not close properly, leaving a gap that would allow smoke from one compartment to the other. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0223	Continued from page 2 Maintenance staff will be educated on the importance of ensuring close properly and eliminate any gaps between compartments. The Environmental Services Director/Designee will audit fire barrier doors beginning the week of 9/7/26 weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			K0353	K0353: Sprinkler System - Maintenance and Testing A quarterly sprinkler system tests will be completed quarterly per guidelines. Maintenance staff will be educated on NFPA 25 requirements for quarterly sprinkler system tests. The Environmental Services Director/Designee will audit sprinkler system tests quarterly beginning the week of 9/7/26. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

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K0353 SS = F Bldg. 01	Continued from page 3 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026, at 09:42am, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing during the following quarters: missing third quarter (July - Sept.) and fourth quarter (Oct. - Dec.) An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0353			09/14/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and			K0712	K0712: Fire Drills Fire drills will be completed and held at varied times and conditions per requirements. ESD will develop a fire drill schedule to cover all shifts and quarters and to be held at varied times and conditions. Maintenance staff will be educated on the fire drill procedures and documentation requirements. The Environmental Services Director/Designee will audit fire drills monthly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0712 SS = F Bldg. 01	Continued from page 4 staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/28/2026, at 09:35am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 05/11/26 at 5:45PM, 08/07/26 at 5:17PM, and third shift 04/13/26 at 04:45AM, 07/22/26 at 04:00AM. 2. On 07/28/2026, at 09:35am, it was revealed by a review of available documentation that fire drills were not completed: second shift missing fourth quarter (Oct - Dec.) first shift and fourth quarter (Oct - Dec.) second shift fire drills completely. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0712			09/14/2026
K0225 SS = D Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 19.2.2.3 and section 7.2.2.2.1.1 (b) Table. Minimum width clear of all obstructions, except projections not more than 41/2 in. (114 mm) at or below handrail height on each side. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 07/28/2026, at 10:22am, it was revealed by observation that a rocking chair had been placed in the emergency exit vestibule at the bottom of the emergency stairwell exit in the shared assisted living stairwell.			K0225	K0225: Stairways and Smokeproof Enclosures The rocking chair was removed from the emergency exit at the bottom of the emergency exit stairwell. All stairways and exit enclosures will be inspected. Any obstructions found will be removed so that the emergency exit stairwells are clear. Maintenance staff will be educated on emergency exit stairwell requirements. The Environmental Services Director/Designee will audit stairways and exit enclosures, beginning 9/7/26, weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Compliance date: Sept. 14, 2026		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0225 SS = D Bldg. 01	Continued from page 5 An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0225			09/14/2026
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could have an isolated impact on the residents within the facility. The findings include: On 07/28/2026, at 10:51am, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment			K0324	K0324: Cooking Facilities ESD will install an attachment devices and alignment marks on the wheeled, gas-fired stove and griddle. ESD will review and correct any devices in the kitchen requiring alignment marks and attachment devices. Maintenance staff will be trained on proper appliance placement and required alignment marks and attachment devices. The Environmental Services Director/Designee will audit all wheeled, gas-fired kitchen appliances for alignment marks and attachments devices weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0324 SS = D Bldg. 01	Continued from page 6 device and alignment mark are required for each gas operated cooking device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324			09/14/2026
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility.			K0355	K0355: Portable Fire Extinguishers The items in front of the fire extinguisher noted during the LSC survey were removed to ensure it remains accessible. All fire extinguishers will be checked to ensure that they are accessible and not blocked. Maintenance staff will be educated on requirements to ensure fire extinguishers are accessible and not blocked. The Environmental Services Director/Designee will audit all fire extinguishers weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			K0363	K0363: Corridor Doors The resident room door latch was repaired on room 313 to ensure it latches properly. All door latches will be inspected to ensure they latch properly and corrected if found Maintenance staff will be educated on door-latching requirements. The Environmental Services Director/Designee will audit door latches weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0363 SS = D Bldg. 01	Continued from page 7 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 (1). This deficient finding could have an isolated impact on the residents within the facility. On 07/28/2026, at 10:40am, it was revealed by observation that the resident room door to room 313 does not latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363			09/14/2026
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised			K0918	K0918: Electrical Systems - Essential Electric System A reliability and fuel testing report will be documented for the generator. Maintenance staff will be educated on the generator reliability and fuel testing and documentation requirements. The Environmental Services Director/Designee will audit reliability and fuel testing documentation quarterly. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0918 SS = D Bldg. 01	Continued from page 8 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 101(2012 edition) Life Safety Code, 9.1.3.1, NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. and 8.3.8. This deficient finding could have an isolated on the residents within the facility. Findings include On 07/28/2026, at 09:23am, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability and/or a fuel testing document from a fuel company. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 8 Completion Date: 9/14/26		09/14/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g.,			K0920	K0920: Electrical Equipment - Power Cords and Extension Cords The electrical appliances plugged into power-strips, multi-plug adapters and/or extension cords in the patients room 307 were corrected and plugged directly into a wall receptacle. All areas will be inspected to ensure electrical appliances that are required per guidelines are plugged directly in to the wall receptacles. Maintenance staff will be educated on power-strips,		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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K0920 SS = D Bldg. 01	Continued from page 9 personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/28/2026, at 10:41am, it was revealed by observation that there were electrical appliances plugged into power-strips, multi-plug adapters and/or extension cords in the patients room 307. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920	Continued from page 9 multi-plug adapters and/or extension cords requirements. The Environmental Services Director/Designee will audit power-strips, multi-plug adapters and/or extension cords weekly for 3 months and quarterly thereafter. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include			K0921	All electrically powered medical equipment will be tested per requirements with documentation. Maintenance staff will be educated on requirements of testing electrically powered medical equipment. The Environmental Services Director/Designee will audit the testing of electrically powered medical equipment annually. Results will be reported to QAPI for review and additional action as needed. Responsible Party: Environmental Services Director or Designee Completion Date: 9/14/26		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HERITAGE M... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
(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
K0921 SS = D Bldg. 01	Continued from page 10 information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supped by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/28/2026 at 10:02am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921			09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245245		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - PHASE 4: W... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTHEAST SIXTH STREET , CHISHOLM, Minnesota, 55719			
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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/28/2026. At the time of this survey, Heritage Manor Bldg. 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Heritage Manor Bldg. 02 is a new addition completed in 2022 that includes 21 resident beds. The addition was determined to be built of Type II(111) construction. The addition is fully protected by automatic fire sprinklers and has smoke detection in the corridors, spaces open to the corridors, and resident rooms. Bldg. 02 was surveyed to the requirements of Chapter 18, New Health Care. The facility has a capacity of 65 beds and had a census of 60 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.			K0000			09/04/2026

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 reverse for further 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