

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4UQF  
Facility ID: 00288

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245405</b>  2. STATE VENDOR OR MEDICAID NO. (L2) <b>924240600</b>	3. NAME AND ADDRESS OF FACILITY (L3) <b>HERITAGE LIVING CENTER</b> (L4) <b>619 WEST SIXTH STREET</b> (L5) <b>PARK RAPIDS, MN</b> (L6) <b>56470</b>	4. TYPE OF ACTION: <u>7</u> (L8)  1. Initial                      2. Recertification 3. Termination              4. CHOW 5. Validation                6. Complaint 7. On-Site Visit              9. Other  8. Full Survey After Complaint																
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)  6. DATE OF SURVEY <b>11/07/2016</b> (L34)  8. ACCREDITATION STATUS: <u>    </u> (L10) 0 Unaccredited              1 TJC 2 AOA                              3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) <b>01 Hospital      05 HHA      09 ESRD      13 PTIP      22 CLIA</b> <b>02 SNF/NF/Dual    06 PRTF      10 NF      14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray      11 ICF/IID    15 ASC</b> <b>04 SNF              08 OPT/SP    12 RHC      16 HOSPICE</b>	FISCAL YEAR ENDING DATE: (L35)  <b>09/30</b>																
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :  12. Total Facility Beds <b>52</b> (L18) 13. Total Certified Beds <b>52</b> (L17)	10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>    </u> 1. Acceptable POC ___ 2. Technical Personnel    ___ 6. Scope of Services Limit ___ 3. 24 Hour RN              ___ 7. Medical Director ___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size ___ 5. Life Safety Code        ___ 9. Beds/Room  B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A</b> (L12)																	
14. LTC CERTIFIED BED BREAKDOWN <table style="width:100%; border: none;"> <tr> <td style="text-align: center;">18 SNF</td> <td style="text-align: center;">18/19 SNF</td> <td style="text-align: center;">19 SNF</td> <td style="text-align: center;">ICF</td> <td style="text-align: center;">IID</td> </tr> <tr> <td style="text-align: center;">(L37)</td> <td style="text-align: center;">(L38)</td> <td style="text-align: center;">(L39)</td> <td style="text-align: center;">(L42)</td> <td style="text-align: center;">(L43)</td> </tr> <tr> <td></td> <td style="text-align: center;">52</td> <td></td> <td></td> <td></td> </tr> </table>		18 SNF	18/19 SNF	19 SNF	ICF	IID	(L37)	(L38)	(L39)	(L42)	(L43)		52				15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
18 SNF	18/19 SNF	19 SNF	ICF	IID														
(L37)	(L38)	(L39)	(L42)	(L43)														
	52																	

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

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17. SURVEYOR SIGNATURE  <u>Teresa Ament, Unit Supervisor</u> Date: 11/21/2016 (L19)	18. STATE SURVEY AGENCY APPROVAL  <u>Mark Meath, Enforcement Specialist</u> 01/05/2017 (L20)
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**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY  <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:  _____	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____
22. ORIGINAL DATE OF PARTICIPATION <b>01/01/1987</b> (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44)  B. Rescind Suspension Date: (L45)	
26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <b>00</b> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement  <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.  <b>03001</b> (L28) (L31)	30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE  <b>11/08/2016</b> (L33)	DETERMINATION APPROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245405

January 5, 2017

Mr. Kurt Hansen, Administrator  
Heritage Living Center  
619 West Sixth Street  
Park Rapids, Minnesota 56470

Dear Mr. Hansen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 17, 2016 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Enforcement Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Email: mark.meath@state.mn.us  
Telephone: (651) 201-4118 Fax: (651) 215-9697

*An equal opportunity employer.*



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
November 21, 2016

Mr. Kurt Hansen, Administrator  
Heritage Living Center  
619 West Sixth Street  
Park Rapids, Minnesota 56470

RE: Project Number S5405026

Dear Mr. Hansen:

On October 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2016, effective October 17, 2016 and therefore remedies outlined in our letter to you dated October 7, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Enforcement Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Email: mark.meath@state.mn.us  
Telephone: (651) 201-4118 Fax: (651) 215-9697

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245405	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 11/7/2016	Y3
NAME OF FACILITY HERITAGE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0166	Correction	ID Prefix F0280	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.10(f)(2)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	10/11/2016	LSC	10/11/2016	LSC	10/11/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0314	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed
LSC	10/11/2016	LSC	10/11/2016	LSC	10/11/2016
ID Prefix F0315	Correction	ID Prefix F0371	Correction	ID Prefix	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.35(i)	Completed	Reg. #	Completed
LSC	10/11/2016	LSC	10/11/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) TL/mm	DATE 11/21/2016	SIGNATURE OF SURVEYOR 36536	DATE 11/07/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/22/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245405	Y1	MULTIPLE CONSTRUCTION A. Building 02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS B. Wing	Y2	DATE OF REVISIT 10/17/2016	Y3
NAME OF FACILITY HERITAGE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0062	10/17/2016	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) TL/mm	DATE 11/21/2016	SIGNATURE OF SURVEYOR 36536	DATE 11/07/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/26/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245405	Y1	MULTIPLE CONSTRUCTION A. Building 04 - WEST WING B. Wing	Y2	DATE OF REVISIT 10/17/2016	Y3
NAME OF FACILITY HERITAGE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0062	10/17/2016	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) LB/mm	DATE 11/21/2016	SIGNATURE OF SURVEYOR 29433	DATE 10/17/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/26/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		





PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
October 7, 2016

Mr. Kurt Hansen, Administrator  
Heritage Living Center  
619 West Sixth Street  
Park Rapids, Minnesota 56470

RE: Project Number S5405026

Dear Mr. Hansen:

On September 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

**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.**

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

**Opportunity to Correct** - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

**Electronic Plan of Correction** - when a plan of correction will be due and the information to be contained in that document;

**Remedies** - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;



**Potential Consequences** - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

**Informal Dispute Resolution** - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

**Teresa Ament, Unit Supervisor**  
**Duluth Survey Team**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**

**Email: [Teresa.Ament@state.mn.us](mailto:Teresa.Ament@state.mn.us)**  
**Phone: (218) 302-6151 Fax: (218) 723-2359**

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 1, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 1, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC 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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### **Original deficiencies not corrected**

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### **Original deficiencies not corrected and new deficiencies found during the revisit**

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### **Original deficiencies corrected but new deficiencies found during the revisit**

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

## **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by December 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Heritage Living Center

October 7, 2016

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issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process  
Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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.

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:

**Mr. Tom Linhoff, Fire Safety Supervisor**  
**Health Care Fire Inspections**  
**Minnesota Department of Public Safety**  
**State Fire Marshal Division**

**Email: [tom.linhoff@state.mn.us](mailto:tom.linhoff@state.mn.us)**  
**Telephone: (651) 430-3012 Fax: (651) 215-0525**

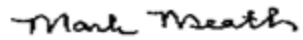
Heritage Living Center

October 7, 2016

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Feel free to contact me if you have questions related to this eNotice.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath". The signature is written in a cursive style with a distinct loop at the end of the last name.

Mark Meath, Enforcement Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health

Email: [mark.meath@state.mn.us](mailto:mark.meath@state.mn.us)

Telephone: (651) 201-4118

Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES


FS405024

PRINTED: 10/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - 1960 BUILDING &amp; 69, 90, 94, 2000 ADDITIONS</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/26/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>
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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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>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.</p> <p>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.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal division. At the time of this survey Heritage Living Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:</p> <p>HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/11/2016
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - 1960 BUILDING &amp; 69, 90, 94, 2000 ADDITIONS</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/26/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>		
(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
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or  Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us  THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:  1. A description of what has been, or will be, done to correct the deficiency.  2. The actual, or proposed, completion date.  3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.  This facility was surveyed as two buildings.	K 000		
	The Heritage Living Center is a one story building with a partial basement under the kitchen area which was constructed in 1960 and is a Type II (111) construction. In 1969 an addition was constructed to the north and was determined to be of Type II (111) construction. In 1990 the chapel addition was constructed to the south and is separated with a 2 hour fire barrier. In 1994 the laundry addition was added to the north and was determined to be of Type II (111) construction and is separated with a 2 hour fire barrier. In 2000 a main entrance addition was added to the chapel addition to connect the nursing home with the new apartment building to the south west and was determined to of Type V (111) construction and is separated from the apartment building with a 2 hour fire barrier. In 2016 a two story resident			

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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>	
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K 000	Continued From page 2 wing replaced the 1960 B-wing and is a Type II (111) construction.  The entire building and additions are sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with sleeping room smoke detection, detection in common areas and at smoke barrier doors that are held open, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The 2016 addition has smoke detection in the resident rooms, corridors and spaces open to the corridors. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification.  The facility has a capacity of 52 beds and had a census of 45 at the time of the survey.	K 000		
K 062 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard	K 062	It is the policy and procedure of Heritage Living Center to maintain automatic sprinkler systems in reliable operating condition and to test periodically. It is also HLC P&P to maintain ceiling tile placement in all areas.	10/17/16



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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>	
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K 062	Continued From page 3 for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect 11 of the 45 residents and an undetermined amount of staff and visitors.  Findings include:  On the facility tour between 8:30 am to 12:00 pm on 09-26-2016 observations and staff interview revealed the following. 1. Four heads in the kitchen dish washing area and two heads in the laundry room were covered with dirt and lint. 2. Ceiling tiles were missing behind the dryers in the laundry room, in the nurses office room N30 and in the employee break room.  This deficient condition was verified by the Maintenance Supervisor	K 062	1. Corrective Action: Sprinkler Systems were cleaned 10/03/16. All ceiling tile will be replaced by 10/17/2016. 2. To prevent reoccurrence: Sprinkler system is in the TEL computer program. Rotation will be followed and sprinklers cleaned on a continuous , rotating basis. 3. QA of ceiling tiles will be done on a weekly basis until Phase Two construction is complete. 4. Monitor Compliance: Environmental Service Director and Administrator 5. Plan of Correction Date: 10/17/2016.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>04 - WEST WING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/26/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>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.</p> <p>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.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal division. At the time of this survey Heritage Living Center Bldg 4 Resident wing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:</p> <p>HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>10/11/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>		
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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or  Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us  THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:  1. A description of what has been, or will be, done to correct the deficiency.  2. The actual, or proposed, completion date.  3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.  This facility was surveyed as two buildings.	K 000		
	The Heritage Living Center is a one story building with a partial basement under the kitchen area which was constructed in 1960 and is a Type II (111) construction. In 1969 an addition was constructed to the north and was determined to be of Type II (111) construction. In 1990 the chapel addition was constructed to the south and is separated with a 2 hour fire barrier. In 1994 the laundry addition was added to the north and was determined to be of Type II (111) construction and is separated with a 2 hour fire barrier. In 2000 a main entrance addition was added to the chapel addition to connect the nursing home with the new apartment building to the south west and was determined to of Type V (111) construction and is separated fromt the apartment building with a 2 hour fire barrier. In			

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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>		
(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	
K 000	Continued From page 2 2016 a new two story resident wing replaced the 1960 B-wing and is a Type II (111) construction.  The entire building and additions are sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with sleeping room smoke detection, detection in common areas and at smoke barrier doors that are held open, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The 2016 addition has smoke detection in the resident rooms, corridors and spaces open to the corridors. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification.  The facility has a capacity of 52 beds and had a census of 45 at the time of the survey.	K 000			
K 062 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of	K 062	It is the policy and procedure of Heritage Living Center to keep ceiling tile clean and in place throughout the facility. 1. Corrective Action: Ceiling tile was put back in place 09/26/2016. 2. To prevent further reoccurrence: Daily walk around and weekly QA will be done	10/17/16	

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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 WEST SIXTH STREET PARK RAPIDS, MN 56470</b>		
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K 062	<p>Continued From page 3</p> <p>Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect 16 of the 45 residents and an undetermined amount of staff and visitors.</p> <p>Findings include:</p> <p>K62 On the facility tour between 8:30 am to 12:00 pm on 09-26-2016 observations and staff interview revealed a ceiling tile missing in the first floor dining area near the connecting link.</p> <p>This deficient condition was verified by the Maintenance Supervisor.</p>	K 062	<p>per maintenance department to make sure tiles have been put back in place after construction work is completed. This will be done until Phase Two of construction is completed.</p> <p>3. Compliance will be monitored by: Environmental Service Director and Administrator.</p> <p>4. Plan of Correction Date: 10/17/16.</p>		