Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 30, 2023

Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, MN 55719

RE: CCN: 245245
Cycle Start Date: March 9, 2023

Dear Administrator:

On April 19, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 28, 2023

Administrator
Heritage Manor
321 Northeast Sixth Street
Chisholm, MN 55719

RE: CCN: 245245
Cycle Start Date: March 9, 2023

Dear Administrator:

On March 9, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 9, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 9, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
E 000	Initial Comments On 3/6/23-3/9/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=D	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		4/17/23

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

Electronically Signed | 04/03/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
E 041	Continued From page 3 Based on document review and staff interview, the facility failed to test the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.5.4.1.1.2 and 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/13/2023 at 1:10 PM, a review of available documentation revealed that no evidence could be provided of a monthly run test under load being conducted on the emergency generator for February 2023. An interview with the Director of Maintenance verified this finding at the time of discovery.	E 041	In order to comply with NFPA 99 (2012 edition), Health Care Facilities Code, section 6.5.4.1.1.2 and 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 the ESD conducted a monthly run test under load on the emergency generator on 4/3/23. ESD and/or a competent designee will conduct monthly run exercises of the generator, under load, on the emergency generator the first week of every month to ensure the generator is meeting the monthly load and operating conditions. Administrator will oversee and audit the monthly generator exercise schedule to ensure the generator is meeting the monthly requirements.	
F 000	INITIAL COMMENTS On 3/6/23-3/9/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed and were found to be in compliance with no deficiency issued: H52459002C (MN90300) H52459003C (MN88115) H5245053C (MN79838) AND	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 000	Continued From page 4 The following complaint was reviewed. H5245055C (MN82253) and was found to be not in compliance with a deficiency issued at F677. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete all sections on the Minimum Data Set (MDS) for 2 of 15 residents (R40, R38) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, "OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care	F 641	Modification of R40 admission MDS dated 2/17/23 was completed on 3/8/23 by DON/MDS Coordinator modifying Section O. 0100 reflecting dialysis. Modification of R38 significant change MDS dated 1/17/23 was completed on 3/8/23 by DON/MDS Coordinator modifying Section E. 0100 by selecting A and B in this section to reflect hallucinations and delusions. All residents who receive dialysis services and/or have hallucinations and/or	4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 641	Continued From page 5 planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required." Section O: identified special treatment, procedures, and programs. "The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods." Section E: behavior. "The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. This section focuses on the resident's actions, not the intent of his or her behavior. Because of their interactions with residents, staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent (e.g., "Mr.	F 641	delusions have the potential to be affected by the deficient practice. The MDS 3.0 Assessment Policy was reviewed by the DON with no changes needed on 3/31/23. MDS Coordinator will be educated on the MDS 3.0 Assessment Policy in regard to how to accurately code Section O by the DON and/or designee. Social Services Director will be educated on the MDS 3.0 Assessment Policy in regard to how to accurately code Section E by the DON and/or designee. MDS Coordinator will be educated on reviewing all Sections of the MDS as a whole for accuracy prior to signing off as completed by the DON and/or designee. All residents who receive dialysis will have their Section O reviewed for all MDS's going back 3 months for accuracy by the MDS Coordinator and/or designee. All residents who have hallucinations and/or delusions will have Section E reviewed for all MDS's going back 3 months for accuracy by the Social Services Director and/or designee. Random MDS audits on Section O and Section E will be completed by DON and/or designee 3x/week x 2 weeks, then once weekly thereafter for coding accuracy. Auditing will begin on 4/3/23. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 641	Continued From page 6 A. doesn't really mean to hurt anyone. He's just frightened."). Resident intent should not be taken into account when coding for items in this section. R40's admission Minimum Data Set (MDS) dated 2/17/23, indicated R40 had diagnoses which included anemia, hypertension, endstage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hyperlipidemia, and anxiety. R40's admission MDS dated 2/17/23, section O-special treatment, procedures, and programs revealed the following: O. 0100 Special treatments and programs Z. none of the above was checked (dialysis was not checked). R38's significant change MDS dated 1/17/23, indicated R38 had diagnoses which included anemia, hypertension, hyperlipidemia, arthritis, seizures, and depression. R38's Face Sheet dated 3/9/23, indicated R38 had major depressive disorder, recurrent, severe with psychotic symptoms and dementia. R38's significant change MDS dated 1/17/23, revealed the following: E. 0100 Z. none of the above was checked (which were hallucinations and delusions). During an interview on 3/8/23, at 1:59 a.m. registered nurse (RN)-A verified R40 was receiving dialysis three times a week and that it	F 641	recommendations for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 641	Continued From page 7 was not listed in his MDS dated 1/17/23. RN-A said it would have been important to note he was receiving dialysis treatments on the MDS as it would have been used to develop his care plan and it was necessary for payment. During an interview on 3/9/23, at 10:15 a.m. the director of nursing (DON) verified dialysis was missing as a treatment on R40's MDS dated 1/17/23. She said it would have been important to note it on the MDS as it would have been used to develop R40's care plan, for example weights and directing staff to monitor his dialysis access site. The DON verified R38's MDS should have noted she was having hallucinations and delusions. The DON stated this would have justified the medications R38 was taking and would have been needed to develop her care plan. The policy titled MDS 3.0 Assessment dated 10/13/21, directed staff to conduct comprehensive, accurate and standardized assessments of each resident, using the Resident Assessment Instrument (RAI) manual and Regulations and Rules specified by the Centers for Medicare and Medicaid and the State of Minnesota.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 677	R26 had peri-cares, face and hands	4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 677	Continued From page 8 review, the facility failed to complete morning cares for 1 of 3 residents (R26) reviewed for personal cares. Findings include: R26's health conditions dated 3/9/23, indicated R26's diagnoses included low back pain, major depressive disorder, and weakness. R26's significant change Minimum Data Set (MDS) dated 12/26/22, indicated R26 was severely cognitively impaired and required extensive assistance with personal hygiene, dressing, and toilet use. R26's care plan dated 6/24/22, indicated R26 required extensive assistance with grooming and personal hygiene. Staff were directed to encourage R26 to start grooming tasks and to assist with completion if he was unable. On 3/8/23, at 7:18 a.m. until 7:47 a.m. R26 was continuously observed. R26 was observed lying in bed with his eyes open, wearing oxygen running at two liters per minute. His feet were bare and were sticking out from under his covers. He was wearing a regular shirt. He was able to push his soft touch call light. - At 7:25 a.m. nursing assistant (NA)-A knocked, entered his room, said good morning and said she would be right back with a "pal". - At 7:28 a.m. NA-A returned with a mechanical lift and NA-B. Both NA's performed hand hygiene and put on gloves, they removed R26's oxygen, gathered his clothing, and a new brief. They put his socks on, put on his sweat pants pulling them up to his knees, and put on his shoes. During this	F 677	washed, and oral cares completed on 3/8/23 by NA-A and NA-B. All residents who are dependent on staff for grooming and personal hygiene have the potential to be affected by the deficient practice. The AM Cares Policy was reviewed by DON with no changes needed on 3/31/23. All nursing staff will be educated on the AM Cares Policy by the DON and/or designee in regards to what cares are to be provided for those who need assistance. Random observational audits will be completed to ensure that AM cares are being completed for residents who are dependent on staff for grooming and personal hygiene beginning 4/3/23 by the DON and/or designee. Audits will be completed 3x/week x 4 weeks, then once weekly thereafter. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 677	Continued From page 9 time they were talking to R26 telling him what was going to happen. They assisted him to a seated position on the side of his bed, brought the mechanical lift close to him and attached the straps, he gripped the machines handles and they brought him to a standing position and then brought him into the bathroom, and lowered him to the toilet seat. His old brief was removed by NA-A who then removed her gloves and washed her hands, then put on new gloves. NA-B made his bed. -at 7:37 a.m. NA-A asked R26 if he was done, he said he was and NA-A placed the new brief, he was raised to a standing position and moved out of the bathroom and lowered into his wheelchair. His old shirt was removed, a new shirt was put on, he was given his glasses, and his hat and brought to the common area where the administrator said she would bring him to breakfast. During an interview on 3/8/23, at 10:36 a.m. NA-A stated morning cares included taking residents to the bathroom, helping them wash their face and hands, helping them with brushing their teeth or brushing their dentures for them, and helping them to put on clean clothes. NA-A verified none of that was done for R26. During an interview on 3/8/23, at 10:41 a.m. NA-B said morning cares included peri-care, washing face and hands, taking them to the bathroom, helping them get dressed and making sure their teeth were brushed. NA-B verified this was not done for R26. During an interview on 3/8/23, at 10:45 a.m. licensed practical nurse (LPN)-A stated morning cares included washing a residents face, hands,	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 677	Continued From page 10 "bottom", making sure they had clean clothes, and that oral care was completed. During an interview on 3/9/23, at 10:25 a.m. the director of nursing (DON) stated she would expect staff to help a resident wash their face, hands, under their arms, and peri-care as part of morning cares. The DON stated brushing teeth was an expectation as part of morning cares as well. The policy A.M. Cares no date, directed the staff to complete the following steps: 1. Introduce self and explain procedure to the resident. 2. Adjust windows and draw the drapes. 3. Offer or take the resident to the bathroom. If unable to toilet, check incontinent product and change as needed. 4. Provide assistance with perineal care per the resident plan of care. 5. Resident shaved per the plan of care. 6. Allow resident to brush teeth, or assist with oral hygiene if he/she is not able. 7. Wash resident's face, hands and underarms and dry well. Encourage resident participation. 8. Straighten and/or change all bed linen, blankets and spread as needed. 7. Position the resident comfortably. 8. Put call light within easy reach. 9. Prepare bedside stand to receive breakfast if eating in room. 10. Leave bedside area clean and resident comfortable. 11. Report unusual or abnormal conditions and symptoms to nurse.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 761	Continued From page 11	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper sanitary storage of resident medications within the medication cart and that expired medications were removed from surplus stock supply. In addition, the facility failed to ensure only authorized personnel had access to keys to get at drugs and biologicals stored in the medication room and the medication cart.	F 761	LPN-A was educated on 3/8/23 by DON on always keeping medication cart keys on person. All residents have the potential to be affected by this deficient practice. The Medication Storage Policy was reviewed and revised by DON on 4/11/23.	4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 761	Continued From page 12 Findings Include: On 3/8/23, at 10:59 a.m. licensed practical nurse (LPN)-A locked the medication cart located in front of the nurse's station, placed medication keys on cart surface and walked over to fridge to get milk while the keys remained on the cart. At 11:00 a.m. LPN-A proceeded into resident room with milk to administer pills. At 11:02 a.m. LPN-A returned to the medication cart and sanitized hands. On 3/8/23, at 11:14 a.m. the medication cart was parked across from the nurse's station. The medication cart keys were hanging on the cart computer arm. LPN-A was not in sight. Continuous observation of cart initiated. On 3/8/23, at 11:19 a.m. unknown staff used a different set of medication keys to access the medication cart. LPN-A's keys remained hanging on the computer arm. On 3/8/23, at 11:22 a.m. LPN-A returned to the mediation cart and picked up medication keys. On 3/8/23, at 11:37 a.m. LPN-A confirmed the keys left on the cart gained access to the medication room, medication cart, and the locked boxes within the cart containing narcotics. LPN-A stated normally if I go far away from the cart, I grab the medication keys, but if I go into a resident room, I have left the keys on the cart. LPN-A stated it was not okay to leave the keys unattended, the keys should always be kept on the medication nurse's person. On 3/8/23, 02:43 p.m. the director of nursing	F 761	All licensed nurses will be educated on the Medication Storage Policy in regards to keeping the medication cart locked and medication keys on them at all times by the DON and/or designee. Random audits will be completed by the DON and/or designee to monitor for compliance with medication carts being locked with the keys in the presence of the licensed nurse 3x/week x 4 weeks, then weekly thereafter beginning 4/3/23. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. LPN-A placed all topical ointments on the Park Addition medication cart in individual plastic bags on 3/8/23. All residents in the Park Addition have potential to be affected by this deficient practice. The Medication Storage Policy was reviewed and revised by DON on 4/11/23. All licensed nurses will be educated on the Medication Storage Policy in regard to storing topical ointments in individual plastic bags to prevent mixing by the DON and/or designee. Random audits will be completed by the DON and/or designee to monitor for compliance with topical ointments being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 761	Continued From page 13 (DON) stated medication keys should not be left on top of the cart, or anywhere unattended, the keys should be always kept with the medication nurse in a pocket. On 3/8/23, at 11:23 a.m. the bottom drawer of the medication cart contained a handled bin with resident topical medications stored in plastic bags. A second bin contained medical tape and supplies for measuring and staging wounds. The bin also contained two unbagged Nystatin topical powders. (Nystatin powder is a medication used to treat fungal infections of the skin). LPN-A removed the powders from the wound bin and stated the powders should not be in the cart without being in a plastic bag, and the powders should be stored in the handled bin with the other topical medications (already in bags). LPN-A verbalized concern about using the wound measuring supplies after the nystatin powder had been mixed in with the supplies. The smaller bottom drawer contained a compartment of resident topical ointments and creams in plastic bags stored together. One tube of diclofenac sodium topical gel 1% was not stored in a bag. LPN-A stated the cream should be in a bag and stated she would be bagging all items as soon as she got some bags. On 3/8/23, at 2:22 p.m. LPN-B confirmed the medication stock supply contained four bottles of expired Mylanta dated 1/2023 and seven Vesta daily Moisturizer tubes with an expiration date of 2/2023. Registered nurse (RN)-B was also in the medication room and stated the person that orders stock medications does a review of expiration dates before an order is placed and	F 761	placed in individual plastic bags to prevent mixing 3x/week x 4 weeks, then weekly thereafter beginning 4/3/23. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. LPN-B destroyed expired bottles of Mylanta and Vesta daily moisturizer tubes on 3/8/23 in the Central Ave. medication room. All residents who reside on Central Ave. have potential to be affected by this deficient practice. The Medication Storage Policy was reviewed and revised by DON on 4/11/23. All licensed nurses will be educated on the Medication Storage Policy in regard to destruction of expired medication and moisturizers in medication storage rooms to ensure there are no expired medications in these locations. Education will include that nursing staff will check expiration date prior to utilizing medications or ointments that are in the overstock medication storage room and destroy if discovered to be expired. Nursing staff will conduct weekly audits of the medication storage room and destroy any expired medications and moisturizers ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 761	Continued From page 14 typically pulls expired mediations from stock if anything was expired. In addition, night nurses check stock medications for expiration dates. On 3/8/23, 2:43 p.m. the DON stated stock medications were ordered twice a month. During the ordering process, current stock medications were reviewed to determine what needs to be ordered. At this time expired stock medications would be removed from inventory. Nurses also looked at stock medications and disposed of items that were expired. Facility policy Medication Storage instructed the following: "The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. The medication cart is to be locked at all times when the licensed nurse is not present and medication cart keys shall be kept with the licensed nurse. The keys for the medication room are to be kept with the licensed nurse. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent	F 761	Random audits will be completed by the DON and/or designee to monitor for expired medications and/or moisturizers being stored in medication storage rooms for compliance 3x/week x 4 weeks, then weekly thereafter beginning 4/3/23. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	321 NORTHEAST SIXTH STREET CHISHOLM, MN 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
F 761	Continued From page 15 the possibility of mixing medications of several residents."	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 000	INITIAL COMMENTS FIRE SAFETY The Minnesota Department of Public Safety, State Fire Marshal Division, conducted an annual life safety recertification survey on 03/13/2023. 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.	K 000		

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

Electronically Signed | 04/04/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 000	Continued From page 2 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. A newly constructed addition was completed and occupied in 2022 and will be surveyed under Chapter 18, New Construction. The facility has a capacity of 65 beds and had a census of 57 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=E	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.	K 324		4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 324	Continued From page 3 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking appliances in a neighborhood kitchen per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3. This deficient finding could have a patterned impact on the residents within the smoke compartment. Findings include: On 03/13/2023 at 2:42 PM, observation revealed that the neighborhood kitchenette was open to the egress corridor and had a convection oven with no isolation lockout switch and safety timer. An interview with the Director of Maintenance verified this finding at the time of discovery.	K 324	In order to comply with CFR(s): NFPA 101 ESD NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3. Environmental Services Director (ESD), with Administrator oversight will contact an electrical contractor to come onsite and install a safety switch or lockout device on the Windy Hill neighborhood kitchen oven. Periodic audits will be conducted to ensure the safety switch or lockout device is in place and functioning. ESD and/or designee will be responsible for the corrective actions and monitoring of compliance.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state	K 351		4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 351	Continued From page 4 or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install an automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.3.3.2. This finding could have a patterned impact on the residents within the smoke compartment. Findings include: On 03/13/2023 at 2:25 PM, observation revealed that there appeared to be a mixture of quick-response intermediate temperature frangible bulb sprinklers and standard response ordinary temperature fusible link sprinklers in the lower-level corridor. An interview with the Director of Maintenance verified this finding at the time of discovery.	K 351	In order to comply with NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.2, and NFPA 13 (2010edition), Standard for the Installation of Sprinkler Systems, section 8.3.3.2., ESD will contact a sprinkler contractor to come onsite and replace the standard response - fusible link sprinkler heads in the lower-level corridor with quick-response intermediate temperature frangible bulb sprinklers. Annual inspections will be completed on care center sprinklers auditing to ensure all are the same style for that area and in compliance with LSC by the ESD and/or designee.	
K 353 SS=F	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,	K 353		4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 353	Continued From page 5 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 _____ 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, 9.7.6, and 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.3.1.1.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/13/2023 at 12:48 PM, a review of available documentation revealed that the annual sprinkler report noted that fast response sprinklers were 20 years old and were not sample tested. In addition, no evidence existed of the sample test being done after the report was issued. An interview with the Director of Maintenance verified this finding at the time of discovery.	K 353	In order to comply with NFPA 101 (2012 edition),Life Safety Code, section 9.7.5, 9.7.6, and 9.7.7,and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section5.3.1.1.1.3 ESD will contact their sprinkler contractor of record to determine if there is any previous documentation of sample testing of the facilities fast response sprinklers. If one was not completed within the last 10 years, the facility will have a sprinkler contractor complete a sample testing of the facilities fast response sprinklers. ESD will set-up 10-year routine inspection schedule to ensure future sample testing of sprinkler heads is done Annual audits records will be kept to verify the sprinkler head testing is being monitored.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 918 SS=C	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 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	K 918	In order to comply with NFPA 99 (2012	4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 918	Continued From page 7 the facility failed to test the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.5.4.1.1.2 and 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/13/2023 at 1:10 PM, a review of available documentation revealed that no evidence could be provided of a monthly run test under load being conducted on the emergency generator for February 2023. An interview with the Director of Maintenance verified this finding at the time of discovery.	K 918	edition), Health Care Facilities Code, section 6.5.4.1.1.2 and 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. ESD conducted a monthly run test under load on the emergency generator on (date). ESD and/or a competent designee will conduct monthly run exercises of the generator, under load, on the emergency generator the first week of every month to ensure the generator is meeting the monthly load and operating conditions. Administrator will oversee and audit the monthly generator exercise schedule to ensure the generator is meeting the monthly requirements.	
K 000	INITIAL COMMENTS FIRE SAFETY The Minnesota Department of Public Safety, State Fire Marshal Division, conducted an annual life safety recertification survey on 03/13/2023. At the time of this survey, Heritage Manor Bldg. 02 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 18 New 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 000	Continued From page 8 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: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 000	Continued From page 9 future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 57 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 918 SS=C	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.	K 918		4/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 918	Continued From page 10 Generator sets are inspected weekly, exercised 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.5.4.1.1.2 and 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/13/2023 at 1:10 PM, a review of available documentation revealed that no evidence could	K 918	In order to comply with NFPA 99 (2012 edition), Health Care Facilities Code, section 6.5.4.1.1.2 and 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. ESD conducted a monthly run test under load on the emergency generator on (date). ESD and/or a competent designee will conduct monthly run exercises of the generator, under load, on the emergency generator the first week of every month to ensure the generator is meeting the monthly load and operating conditions. Administrator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245245	A. BUILDING **01, 02** B. WING _____	**03/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	**321 NORTHEAST SIXTH STREET** **CHISHOLM, MN 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
K 918	Continued From page 11 be provided of a monthly run test under load being conducted on the emergency generator for February 2023. An interview with the Director of Maintenance verified this finding at the time of discovery.	K 918	oversee and audit the monthly generator exercise schedule to ensure the generator is meeting the monthly requirements.	