CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5ENO

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AG	ENCY	1	Facility ID: 00288
1. MEDICARE/MEDICAID PROVIDER N (L1) 245405 2.STATE VENDOR OR MEDICAID NO. (L2) 924240600	0.	3. NAME AND ADI (L3) HERITAGE I (L4) 619 WEST SI (L5) PARK RAPII	LIVING CENTE IXTH STREET		(L6)	56470	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUF	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 09/14 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	60 (L18) 60 (L17)	B. Not in Com	ce With quirements	n	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	Following Requirements: 6. Scope of Servi7. Medical Direc8. Patient Room9. Beds/Room (L12)	etor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY ME		(L15)	
60 (L37) (L38)	(L39)	(L42)	(L43)		1001 (6) (1) 01	1601 (j) (1).	(210)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY API	PROVAL	Date:
Jessica Sellner, U		<u> </u>	09/14/2015	(L19)			ogram Specialist	09/24/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible	ticipate		IPLIANCE WITH C ITS ACT:	CIVIL	2. 0		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987	23. LTC AGREEME BEGINNING I		4. LTC AGREEMI ENDING DAT		26. TERMINAT VOLUNTARY 01-Merger, Closu	00	<u>INVOLUN</u>	(L30) TARY leet Health/Safety
(L24)	(L41)		(L25)			W/ Reimbursemer	nt 06-Fail to M	leet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Susp	of Admissions:	(L44)		03-Risk of Involur 04-Other Reason f		OTHER 07-Provider 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	29.	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION (08/27/2015	DF APPROVAL DA			12/2015 Co.		
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245405 September 24, 2015

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 August 31, 2015 the above facility is certified for or recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 24, 2015

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

RE: Project Number S5405025

Dear Mr. Hansen:

On August 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 23, 2015. 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 September 14, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2015 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 July 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 31, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 23, 2015, effective August 31, 2015 and therefore remedies outlined in our letter to you dated August 3, 2015, 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.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245405	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/14/2015
Name	of Facility		Street Address, City, State, Zip Code	
HE	RITAGE LIVING CENTER		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).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y	l) Item		(Y5) [Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0282		08/31/2015		ID Prefix	F0309		08/31/2015		ID Prefix	F0312		08/31/2015
-	483.20(k)(3)(ii)				Reg. #	483.25					483.25(a)(3)		_
LSC				_	LSC					LSC			_
			Compostion					Composition					Compostion
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0371		08/31/2015		ID Prefix	F0431		08/31/2015		ID Prefix	F0441		08/31/2015
Rea.#	483.35(i)				Rea.#	483.60(b), (d), (e)		_		Rea.#	483.65		_
LSC					LSC								_ _
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0456		08/31/2015		ID Prefix			Completed		ID Prefix			Completed
Rea.#	483.70(c)(2)				Reg. #					Reg. #			
•					•			-					_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			_
Reg. #					Reg. #			=		Reg. #			_
LSC				<u> </u>	LSC			-	_	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			_		ID Prefix			_
Reg.#					Reg.#					Reg. #			
LSC					LSC			-		LSC			_
Reviewed By	Revie	wed B	Ву	D	ate:	Signature of	Surve	yor:				Date:	
State Agency	,	JS	S/KJ	0	9/24/20	15		292	49			09/1	4/2015
Reviewed By	Revie	wed B	Ву	D	ate:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed or	n:					-				a Summary of		
	7/23/2015					Unco	rrecte	d Deficiencies	s (C	VIS-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

` ,	Provider / Supplier / CLIA / Identification Number 245405	(Y2) Multiple Constr A. Building B. Wing	BUILDING & 69, 90, 94, 2000 ADDITIONS	(Y3) Date of Revisit 9/18/2015
Name o	of Facility		Street Address, City, State, Zip Code	
HEF	RITAGE LIVING CENTER		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).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			08/31/2015		ID Prefix			08/31/2015		ID Prefix			07/23/2015
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0029				LSC	K0046				LSC	K0050		_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			07/23/2015		ID Prefix			08/31/2015		ID Prefix			07/23/2015
Reg. #	NFPA 101		_		-	NFPA 101		_		Reg. #	NFPA 101		_
LSC	K0054				LSC	K0056				LSC	K0062		
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			08/31/2015		ID Prefix			-		ID Prefix			_
Reg. #	NFPA 101		_		Reg.#			_		Reg. #			_
LSC	K0067		-		LSC			-		LSC			_
			Correction					Correction					Correction
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Reg. #			=		Reg. #			-		Reg. #			_
LSC			-	<u> </u>	LSC			-		LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
			-					-					_
Reg. # LSC			-		Reg. # LSC			-		Reg. # LSC			_
			•	-				•	-				_
Reviewed By	<i>'</i>	Reviewed I	Ву	Da	te:	Signature	of Surve	yor:	•			Date:	
State Agency	у	G	S/KJ	09	0/24/20	15		2720	0			09/1	8/2015
Reviewed By	,	Reviewed I		Da	te:	Signature	of Surve	yor:				Date:	<u> </u>
CMS RO													
Followup to	Survey Comp	leted on:				Check	k for any	Uncorrected	Defici	encies Was	a Summary of	-1	
•		/2015		-			-				to the Facility?	YES	NO
	.,			1									

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5ENO

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY A	GENCY		Facility	y ID: 00288
1. MEDICARE/MEDICAID PROVIDER (L1) 245405 2.STATE VENDOR OR MEDICAID NO (L2) 924240600		3. NAME AND ADD (L3) HERITAGE (L4) 619 WEST SI (L5) PARK RAPII	LIVING CENTE IXTH STREET		(L6) 56470	4. TYPE OF A 1. Initial 3. Terminati 5. Validation	2. ion 4.	2 (L8) Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)		7. PROVIDER/SUF	05 HHA	09 ESRD	<u>02</u> (L'	7) 22 CLIA	7. On-Site V 8. Full Surve	isit 9. ey After Complai	. Other nt
6. DATE OF SURVEY 07 / 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	23/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR 09/3		E: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	60 (L18) 60 (L17)	X B. Not in Com	equirements	n	2. Tec 3. 24 4. 7-1	coved Waivers Of The chnical Personnel Hour RN Day RN (Rural SNF) fe Safety Code	6. Scop 7. Med	e of Services Li ical Director ent Room Size	imit
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SN: 60		ICF	IID		15. FACILITY N	MEETS or 1861 (j) (1):	(L1	5)	
(L37) (L38) 16. STATE SURVEY AGENCY REMA	(L39) RKS (IF APPLICABLE S	(L42) SHOW LTC CANCELL	(L43) .ATION DATE):						
17. SURVEYOR SIGNATURE		Date :				RVEY AGENCY AP		·	Date:
Christi Bodick-Nord,	HFE NEII		08/18/2015	(L19)		Enforcement S	pecialist		08/27/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILI	Participate		IPLIANCE WITH C	CIVIL	2.	Statement of Financi Ownership/Control I Both of the Above :	2 (,	3)
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		VOLUNTARY 01-Merger, Clo 02-Dissatisfacti	on W/ Reimbursemen	05	(L30) VOLUNTARY -Fail to Meet He -Fail to Meet Ag	-
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			luntary Termination n for Withdrawal	07	THER -Provider Status -Active	s Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS	S			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (OF APPROVAL DA	TE (L33)	DETERMIN	JATION APPRO	VAL		
	/			` -/			*****		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 3, 2015

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

RE: Project Number S5405025

Dear Mr. Hansen:

On July 23, 2015, 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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:

Jessica Sellner, Unit Supervisor St. Cloud B Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Jessica.sellner@state.mn.us

Phone: (320) 223-7345 Fax: (320) 223-7348

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 September 1, 2015, 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 September 1, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (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 October 23, 2015 (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 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 January 23, 2016 (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

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us

Telephone: (651) 201-7205

Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 08/20/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
		245405	B. WING _		07/23/	/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) COMPLETION DATE
F 000	INITIAL COMMENT		F 00	00		
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 sic submission of the POC will ion of compliance.				
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 28	32	8/3	31/15
	must be provided by	led or arranged by the facility y qualified persons in ch resident's written plan of				
	by: Based on interview facility failed to prove with the plan of care reviewed for dialysis. Findings include: R54 was admitted to R54's admission Mind 7/8/15, noted R54 viagnosis including	NT is not met as evidenced and document review, the vide services in accordance e for 1 of 1 residents, (R54) s. o the facility on 7/2/15. Inimum Data set (MDS) dated was cognitively intact, had end stage renal disease nellitus, anemia, and		It is the policy of Heritage Living Cefollow each resident's plan of care. 1. Corrective Action: A.) R54 care plan was reviewed. Or 07/24/15 short dialysis care plan with quick access for all staff added to Force communication file. B.)On 07/31/2015 making sure block pressure taken in correct arm was at to CNA Kardex to alert them. C.) On 08/04/2015 education poster wing for the following areas: daily we blood pressure procedures, left upp	n th 854 od added d on eights,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/11/2015

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.

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU A. BUILDING				(X3) DATE COMP	SURVEY LETED
		245405	B. WING _	·····	07/2	3/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	an outside facility. R54's DaVita's dialy instructed staff: -Daily weights shou scale, amount of cle same time with eaction and receiving for a pulsation about the extremity feeling for a pulsation	eceived dialysis treatment at a specific content of the same of thing and approximately the should never be taken on an ains a dialysis access or may access. The specific content of an artery to a vein, used to treatment), and staff was to access daily, which included on in the assess, listening for ope in the access, and eas, warmth or signs of and bandages may be hours following dialysis. (short term) care plan dated the resident was at risk for ead to diabetes mellitus type 2, or dialysis Monday, Wednesday, the dialysis section, the care thad end stage renal disease that end stage renal disease that early light the resident was a site of the care plan did not direct staff was located), report as needed any infection to access site swelling, warmth, or drainage,	F 28	fistula check daily, (feeling for pulsation, listening for a bruit via stethoscope, and assessing area redness, warmth or signs of infe and to remove the access dressings/bandages within six to hours after dialysis. D.) Education provided 08/04/15 charting on return any signs/symbleeding, hemorrhage, bacterium septic shock. E.)Also included in the education 08/04/2015: On return from dialy (LPN/RN)is to check paperwork dialysis unit and chart dialysis we Point Click Care, obtain full set of check for bruit/thrills, and monitorsigns of bleeding at the site. F.) Instructions were added to trusheet on 08/04/15 by MDS Coor 2. Corrective Action as it relates residents: A.) Short care plan added to communication book for quick streference. B.) Education provided to staff for residents on dialysis with emphasindividual needs for each resider (08/06/15 new manuals reviewed staff.) C.) Instructions added to treatmer for each resident on dialysis. D.) Policy and Procedure for dial written and shared with staff 08/08/20/15. 3. Re-occurrence will be prevent A.) QA audit will be done weekly days and then monthly for 60 days and then m	eight on ptoms of n, and n on esis nurse from the eight in of vitals, or for eatment dinator. to other aff or all sis on ont. d with ent sheet ysis 05/15- ed by: for 30 ys to	
ORM CMS-25	667(02-99) Previous Versions		1		nuation sheet I	Page 2 of 27

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED	
		245405	B. WING			07/:	23/2015	
	PROVIDER OR SUPPLIER GE LIVING CENTER			61	REET ADDRESS, CITY, STATE, ZIP CODE 9 WEST SIXTH STREET ARK RAPIDS, MN 56470	T .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	weight in Point Clici record), obtain full shruit/thrills, and mo sight. During interview on practical nurse (LPI R54's access site of stated she did not derecord. LPN-A state weighed three time looked in R54's mewas only two weigh admission on 7/2/12. During interview on stated staff do not learn from dialysis covered by gauze a and she removes it the facility. R54 state never listened or fewhen interviewed on the facility of the facility	Care (computerized patient set of vital signs, check for nitor for signs of bleeding at 7/22/15, at 8:43 a.m. licensed N)-A stated she does check nce per shift, however, she locument this in the medical ed dialysis patients get set per week, however, LPN-A dical record and verified there at scompleted for R54 since 5. 7/22/15, at 8:52 a.m. R54 ook at her access site on her R54 stated her fistula is and tape when leaving dialysis, herself after she returns to uted staff at the facility have	F 2	82	B.) QA results will be taken to QA committee to see if further action is required. 4. The POC will be monitored by U Manager, MDS Coordinator and DC 5. Correction Date: 08/31/2015	nit		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (X:	B) DATE SURVEY COMPLETED
		245405	B. WING _		07/23/2015
	HERITAGE LIVING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
F 282 F 309 SS=D	July 2015, failed to weights or treatmer dialysis care or ass Review of facility precord from 7/2/15 7/8/15, 7/13/15 prewere noted, however weights from the retreatment of the facility policy titreview dated 5/11, it care plan is to assurat admission, to assurat admission, and to process of developic comprehensive car resident, family, repinterdisciplinary teatment of the comprehensive data. 25 PROVIDE OF HIGHEST WELL BUT Each resident must provide the necessor maintain the high mental, and psycholaccordance with the and plan of care. This REQUIREMENT by: Based on interview	identify an order for special nt related to pre or post essment. ogress notes from R54's - 7/23/15, indicated 7/6/15, and post dialysis weights er, there were no other maining days of dialysis. Eled Care Planning Team ndicated the purpose of the are continuity of care at re residents' needs can be bet to provide a system for ongoing and updating a e plan with input form the presentative, and an m. It also noted areas of luded in the initial care plan, asive care plan is used by all in the care of the resident. CARE/SERVICES FOR	F 28		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		SURVEY PLETED
		245405	B. WING		07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01,1	-0,-010
HEDITAC	E LIVING CENTER		(619 WEST SIXTH STREET		
HERITAG	E LIVING CENTER			PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 4	F 309			
	of 1 residents (R54) reviewed for dialysis.		to attain or maintain the highest		
	Findings include:	,		practicable physical, mental, and psychosocial well-being, in accorda with the comprehensive assessme		
	R54 was admitted t	to the facility on 7/2/15.		plan of care. 1. Corrective Action:	in and	
	7/8/15, noted R54 vidiagnosis including (ESRD), diabetes in hypertention, and rean outside facility. R54's DaVita's dialy instructed staff: -Daily weights shous cale, amount of clasame time with each elbood pressure shextremity that contains be used for future a lt also noted R54 kg	ould never be taken on an ains a dialysis access or may access. nad a left upper arm fistula		A.) See under F-282 also. B.) Care Plan reviewed and a shor dialysis care plan put in communic book 07/29/15 for easy access to s C.) On 08/04/15 education was proto staff related to dialysis instruction D.) On 08/04/15 treatment sheet wupdated to include needed plan of items. E.) Weekly QA will be done for 30 and then QA will be done monthly days to ensure compliance. 2. Corrective Action as it relates to residents: A.) See under F-282 also. B.) All residents on dialysis had cally	ation staff. byided ns. ras care days for 60 other	
	administer dialysis check the extremity feeling for a pulsati a bruit via stethosca assessing for reducinfectionAccess dressings removed within 6-8 R54's facility initial 7/2/15, indicated the complications related and receiving hemoland Friday. Under the plan indicated R54	of an artery to a vein, used to treatment), and staff was to access daily, which included on in the assess, listening for ope in the access, and ess, warmth or signs of and bandages may be hours following dialysis. (short term) care plan dated e resident was at risk for ed to diabetes mellitus type 2, odialysis Monday, Wednesday, the dialysis section, the care had end stage renal disease entions included no blood		reviewed. Short care plan added to dialysis communication book 07/29 C.) Treatment sheets update 08/04 include all needed dialysis actions. D.) Education provided to staff 08/05 E.) QA monitoring will be done were 30 days and then monthly for 60 diensure compliance. 3. Re-occurrence will be prevented A.) QA audits will be done as state above. B.) QA results will be taken to QA committee to determine if further a needed. C.) Education books will be available each floor for easy access to inform as staff needs. This will be completed.	9/15. 4/15 to 05/15. ekly for ays to I by: d ction is	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED
		245405	B. WING		07	/23/2015
	PROVIDER OR SUPPLIER GE LIVING CENTER	619 WEST SIXTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	had a fistula, and the where the access of monitor/document/signs/symptoms of including redness, sometimes, symptoms of bacterium, and sepupon return from disveight in Point Clic record), obtain full sometimes bruit/thrills, and mosight. During interview on practical nurse (LP R54's access site of stated she did not of record. LPN-A stat weighed three time looked in R54's me was only two weight admission on 7/2/1 During interview on stated staff do not be return from dialysis covered by gauze a and she removes it the facility. R54 stanever listened or fer when interviewed on R54, and there was series access to the facility of th	th graft (although the resident the care plan did not direct staff was located), report as needed any infection to access site swelling, warmth, or drainage, report as needed bleeding, hemorrhage, stic shock, check paperwork alysis, and chart dialysis k Care (computerized patient set of vital signs, check for nitor for signs of bleeding at 17/22/15, at 8:43 a.m. licensed N)-A stated she does check once per shift, however, she document this in the medical ed dialysis patients get s per week, however, LPN-A edical record and verified there at completed for R54 since 5. 17/22/15, at 8:52 a.m. R54 ook at her access site on her . R54 stated her fistula is and tape when leaving dialysis, it herself after she returns to ated staff at the facility have	F 309	08/06/15. 4. The POC will be monitore MAnager, MDS RN, and DC 5. Date of Completion: 08/3	N	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED	
		245405	B. WING _		07	/23/2015	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470			1 01/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W LI w con L	PN-E stated when rould just ask how ompleted monthly PN-E verified there nsure R54's access when interviewed of egistered nurse (R Missing information of the special cares ialysis patient. RN betaining the reside aily, and there show the staff to check the eturns from dialysis. When interviewed of the tated there was not now regarding obtaining R54's physician ordicated there was not necessary the protocol diction of the special protocol diction of the staff to check the eturns from dialysis. S4's physician ordicated no orders nonthly per protocol diction of the special protocol diction of the speci	on 7/23/15, at 10:07 a.m. R54 returns from dialysis she she is doing, and weights are unless ordered otherwise. e is no documentation to as site is being monitored. On 7/23/15, at 2:21 p.m. N)-B stated R54 had some, m' in her medical chart related a staff needed to provide for a l-B verified staff should be ents weight and vital signs ould be an order and direction e access site when R54 is treatment. On 7/23/15, at 8:51 a.m. NA-D othing special staff needed to aining a blood pressure on a check R54's care plan, and of mention about precautions od pressure. Hers from 7/2/15 - 7/23/15, for weights other than oil. edication administration record, for identify an order for special at related to pre or post	F 30	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245405	B. WING _		07/23/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE COMPLÉTION
F 309		ge 7 maining days of dialysis. d to dialysis was requested	F 30	9	
F 312 SS=D	483.25(a)(3) ADL C DEPENDENT RES A resident who is undaily living receives	ARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal	F 31	2	8/31/15
	by: Based on observate review, the facility faci	noted on the admission 18, included senile dementia, on of the retina, and imum Data Set (MDS), dated 14 was rarely/nevering and short term memory extensive assistance of one 14, locomotion on and off the ing, personal hygiene and		It is the policy of HLC to provide the necessary services to maintain good nutrition, grooming, and personal and hygeine. 1. Corrective Action: A.) On 7/23/15 resident allowed state complete cares. Nail care, hair care shaving were completed. B.) DON doing (three times a week two weeks) QA to ensure resident continued to receive grooming nee C.) On 07/27/15 staff involved with residents care was re-educated on to report to charge nurse or Unit M if a resident refused care. D.) Education also provided on way approach resident if she was comb with cares. E.) Weekly QA checks will be doned three months starting 08/01/15 by conurse/UM/DON. 2. Corrective Action as it pertaind to	aff to e and of for ds. need anager ys to pative e for charge

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	SURVEY PLETED
		245405	B. WING			07/2	23/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 19 WEST SIXTH STREET ARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	to give clear explar to and during each assistance with act staff were to reassiminutes later and treatment further indicated Reliving (ADL) self-ca interventions to, "Coclean on bath day a During an observat R14 was sitting in the room. R14 had long dark brown substarespecially on the rigseveral one-half indicated and under the chinal during observation was again sitting in facial hair and long During an observat R14 was sitting at the eating breakfast. Riggged, and dirty, at the upper lip and chinal direction was usually perform bath, and as needed received a bed bath unsure why R14 did facial hair shaved, the staff of the responsible to ensure was usually perform bath, and as needed received a bed bath unsure why R14 did facial hair shaved, the reason of the received a bed bath unsure why R14 did facial hair shaved, the reason of the received a bed bath unsure why R14 did facial hair shaved, the reason of the	nation of all care activities prior contact, and if R14 resists ivities of daily living (ADL), are R14, leave, and return 5-10 ry again. The plan of care 14 had an activities of daily re performance deficit with heck nail length and trim and and as necessary." ion on 7/21/15, at 1:30 p.m., he wheelchair in the dining g, jagged fingernails, with a noce noted under the nails, ght hand. R14 also had ch facial hairs on the upper lip on 7/22/15, at 2:29 p.m., R14 the dining room, and the dirty fingernails remained. ion on 7/23/15, at 8:18 a.m., he table in the dining room, 14's fingernails remained long, nd the facial hair remained on	F3	:12	residents: A.)On 08/04/15 education provided nursing staff on proper cares and word of a resident refuses. B.) A QA audit of random residents conducted weekly for one month at monthly for three months. C.) Results will be taken to QA come to determine if further action is need D.) Nursing staff meetings will be hos/11/15, 08/12/15 and 08/13/15 to education material. 3. Re-occurrence will be prevented A.) QA audits as mentioned above results taken to IDT and QA Comme for further action. B.) Annual staff education on dealing residents who refuse cares. Educated given 08/04/15. A follow up inservice be provided Sept. 16th, 2015 by Mareyes, Awakening RN. 4. The POC will be monitored by: Onurse, Unit Manager and DON. 5. Correction Date: 08/31/15.	what to will be and then amittee ded. eld review by: with ittee ag with tion e will aria	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	During an interview NA-C stated she had 7/22/15, and verified removal were not co on 7/22/15, although why. During an interview family member (FM consistently provide R14's nail care and stated, "I mentioned again." FM-A stated nursing (DON) a few better about ensurin however, lately she completed. FM-As facial hair, adding, "herself. I think the fashe was still aware. During an interview DON stated staff ar registered nurse or having trouble compares resident refuses of and go back five min have someone else.	e completed at a later time. on 7/23/15, at 8:50 a.m., ad given R14 a bed bath on d R14's nail care and hair ompleted after giving the bath h NA-C could not indicate on 7/23/15, at 9:57 a.m., l)-A indicated the staff did not e grooming assistance for facial hair removal, and d it a couple of weeks ago l she had talked to director of w months ago and staff got ng the cares were complete, felt the cares were not being tated R14 used to pull out the l'[R14] always took care of that acial hair bothered [R14] when of her surroundings." on 7/23/15, at 10:39 a.m., e instructed to go to the to the unit manager if they are pleting cares for a resident. If cares, staff are trained to wait inutes later to try again, or to	F 31			
F 371 SS=F	483.35(i) FOOD PR	ROCURE, 'SERVE - SANITARY	F 37	71		8/31/15
				The state of the s		i '

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIF 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CX (EACH CORRECTIVE ACTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 371	considered satisfact authorities; and (2) Store, prepare, under sanitary conductors. This REQUIREMED by: Based on observareview, the facility for authorities;	om sources approved or story by Federal, State or local distribute and serve food	F3	It is the policy of Heritage store,prepare,and distribu sanitary conditions as app	ite food under	
	controls for the saft facility also failed to levels for sanitization equipment cleaned three-compartment affect all 46 resider meals from the facility from the facility for the initial kit buring the initial kit	e storage of food items. The ensure required chemical on were maintained for kitchen using the facility's sink. This had the potential to the who were routinely served		Federal, State and local a 1 Corrective Action and 2: Action as it relates to all re A.)Staff to check temps de refridgerator and notify CI Environmental Service Su proper temperature range B.) Three compartment si tested at least daily by die monthly by Ecolab service C.) Staff education was pr appropriate tempratures	authorities. Corrective esidents: aily on DM or upervisor if not in a. inks will be etary staff and e representative. rovided on	
	the exterior thermo temperature readin (F). However, a the cooler read 46 deg was unsure of why blinking on the coo Also during the tou noted as equipped sink with chemical for high temperature.	meter blinking and a g of 43 degrees Fahrenheit irmometer located inside the rees F. Cook (C)-A stated he the temperature reading was ler's exterior thermometer. r, the facility's kitchen was with both a three-compartment sanitization, and a dish washer		not in acceptable range. E provided to dietary staff or chemical strips the three contential room. 3. Re-occurrence will be particular to a compliant temperature logs and san B.) QA weekly for 90 days to ensure adequate stock	Education also notesting with compartment ocked in corevented by: y for 90 days by ce with ditizer checks. s (and on going)	

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245405	B. WING		07/3	23/2015
	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 371	facility's meat coole with a temperature interior thermomete a.m., after C-B and and closed the coopreparation, the exto blink, with a temperature to blink, with a temperature to blink, with a temperation activities continued to blink, 45 degrees F and a of 48 degrees F. The consistently revealed approximately three thermometer. During stated the exterior on and off repeated outage, but she did blinking for several pressing the reset is supposed to resolv she tried to reset it, thereafter. C-B condictary manager (Concerns, and she all temperature logic coolers and freezer. Also during this foll three-compartment various fluids/ solutholding one plastic manufacturer of no weaved plastic mat stated most dishes through the dish was stated to the coolers and the coolers and stated most dishes through the dish was stated most dishes through the dishes the dishes the cooler and the cooler	erior thermometer of the er was observed as blinking, reading of 37 degrees F. The er read 40 degrees F. At 11:10 dietary aide (DA)-A opened ler several times during meal terior thermometer continued perature reading of 42 degrees mometer read 45 degrees F. ing the end of meal es, the exterior thermometer with a temperature reading of an interior temperature reading of an interior thermometer ed temperature readings of e degrees F above the exterior ing interview at this time, C-B thermometer typically flashed dly when there was a power I not know why it had been weeks now. She stated button on the cooler was e the blinking, but each time the blinking returned shortly firmed the facility's certified CDM) was aware of these was responsible for review of so for the facility's kitchen	F 371	4. The POC will be monitored by Administrator, Dietary Superviso Environmental Services Supervis 5. Correction Date: 08/31/2015.	r, and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		COMPLETED	
		245405	B. WING _		07	/23/2015	
	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 619 WEST SIXTH STREET PARK RAPIDS, MN 56470			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 371	three-compartment temperature dish w Dycem mats. At the mats were observe area, placed atop no cups turned upside cups pressed again were left to air dry. The three-compartment and logged, however any of the test strip she was typically rethree-compartment chemical levels, how to locate any test is since the beginning facility's CDM was available and state been having a diffic sanitization comparfacility.	colely cleaned using the sink because the high rasher melted the plastic/ at time, several weaved plastic d being used in the dish drying neal trays, with freshly cleaned down, with the lips of the lips the mats while the cups DA-B stated the chemicals for nent sink were tested routinely er, DA-B was unable to locate so At 11:30 a.m., DA-C stated esponsible for testing the sink solution for the required wever, she had been unable trips for testing the chemicals gof the month. She stated the aware there were no test strips d she believed the CDM had cult time getting the chemical my to send test strips to the	F 37	71			
	SHEETS for the factor of the f	ERATOR FREEZER TEMP cility's meat cooler from 22/15, temperatures were ble ranges for 22 out of 71 are recording opportunities, ing:					
	temperature of 62 of On 6/19/15, the day 42 degrees F and to temperature of 43 of On 6/20/15, the day 42 degrees F. On 6/22/15, the day	y shift logged a temperature of he evening shift logged a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	٠, ,	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245405	B. WING		0.	7/23/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	45 degrees F. On 6/27/15, the da 43 degrees F. On 6/28/15, the da 45 degrees F. On 7/2/15, the eve of 52 degrees F. On 7/6/15, the day 48 degrees F and it temperature of 42 On 7/7/15, the day 42 degrees F. On 7/8/15, the eve of 50 degrees F. On 7/9/15, the eve of 42 degrees F. On 7/12/15, the da 42 degrees F and it temperature of 44 On 7/13/15, the eve temperature of 44 On 7/13/15, the da 42 degrees F. On 7/16/15, the da 48 degrees F. On 7/16/15, the da 42 degrees F. On 7/17/15, the da 42 degrees F. The logs also lacke of 71 (24%) of opp logged did not different exterior thermomer notations of "flashir logged during the of	degrees F. y shift logged a temperature of ning shift logged a temperature shift logged a temperature of the evening shift logged a degrees F. shift logged a temperature of ning shift logged a temperature ning shift logged a temperature y shift logged a temperature y shift logged a temperature of the evening shift logged a degrees F. ening shift logged a degrees F. y shift logged a temperature of y shift logged a temperature of	F3	71		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED 07/23/2015	
		245405	B. WING			
_	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 619 WEST SIXTH STREET PARK RAPIDS, MN 56470	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	facility's three-comp through 7/22/15, ide available for 30 of 6 with entries lacking (52%) entry opportup parts-per million (property operation) in supper meal, was to recorded during this. During interview on CDM stated staff with the mometer of contemperature reading the mometers were stated if a cooler to above 41 degrees of the temperature late the cooler was not and if the second to above 41 degrees of the temperature logs for the comperature logs for the cooler was not and if the second to above 41 degrees of the concern to herself of the cooler was not and if the second to above 41 degrees of the concern to herself of the cooler of the cooler was not and if the second to above 41 degrees of the concern to herself of the cooler of the cooler of the meat cooler of the meat cooler. By pasteurized eggs, of the cooler of the meat cooler of the meat cooler of the meat cooler. By pasteurized eggs, of the cooler of the cooler of the meat cooler of the cooler of the meat cooler. By pasteurized eggs, of the cooler of the co	SHER TEMP SHEET for the partment sink from 7/1/15, entified no test strips were 64 (47%) entry opportunities, for an additional 33 of 64 unities. The entry of 400 cm) on 7/13/15, during the ne only test strip result is time period. 7/23/15, at 11:29 a.m. the ere to reference the interior olers/ freezers when logging	F3	71		

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245405	B. WING _		07/	23/2015
	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	testing of the three- stated the facility's of was evaluated mon supplier) and she re TEMP SHEETS dai told her when the ki strips, but she had a date.	d test strips for her routine compartment sink. CDM chemical sanitization system thly by Ecolab (the chemical eviewed the DISHWASHER ly. CDM stated C-C typically tchen had run out of test not been informed of this to	F 3'	71		
F 431 SS=E	directed chemical s tested periodically to and to ensure three preserved in clean a 483.60(b), (d), (e) D	AINKS policy dated 4/1/15, anitizing solutions were to be o maintain appropriate levels accompartment sinks were and sanitary condition.	F 4:	31		8/31/15
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order	nploy or obtain the services of ist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically				
	labeled in accordan professional princip appropriate access					
	facility must store a	State and Federal laws, the Il drugs and biologicals in its under proper temperature				

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	` ' <i>i</i>	DATE SURVEY COMPLETED
	245405	B. WING		07/23/2015
			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET	.,=0,=0.10
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
controls, and perminave access to the The facility must prepresent permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distriquantity stored is meaning the permanent of	it only authorized personnel to keys. ovide separately locked, discompartments for storage of ted in Schedule II of the ug Abuse Prevention and a and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can	F 431		
by: Based on observareview the facility fasecure disposal of analgesic medicatic currently accepted diversion for 5 of 5 R32) reviewed with In addition, the facipharmacy labeling residents (R74 & Rinsulin. Findings include: R59's physician ord Fentanyl Patch evenicogram/hour (mevening shift every patch prior to apply	tion, interview, and document ailed to ensure safe and used Fentanyl (topical narcotic on) patches according to principles to prevent potential residents (R59, R31, R8, R12, prescribed Fentanyl patches. lity failed to ensure accurate was completed for 2 of 4 29) in the facility who receive der dated 7/16/15, indicated by 72 hours, apply 12 cg/hr) transdermally, every 3 day(s) for pain. Remove old ing new patch.		and daily reconcile all controlled drug records in accordance with State and Federal Laws. 1. Corrective Action: A.) The nursing staff were to be signing paper copy of destruction of Fentanyl since change from KNS to PCC electro system. This was not completed on a consistent basis. The destruction of the Fentanyl patch has now been entered in PCC and will trigger an alert if the secon person does not witness and sign with the nurse destroying the old patch. B.) Nurses were educated on the policy and procedure on 07/27/15 regarding Fentanyl patch removal and dating insure.	nto nd he
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa controls, and permi have access to the The facility must pr permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri quantity stored is m be readily detected This REQUIREMEI by: Based on observat review the facility fa secure disposal of analgesic medication currently accepted diversion for 5 of 5 R32) reviewed with In addition, the faci pharmacy labeling residents (R74 & R insulin. Findings include: R59's physician ord Fentanyl Patch even microgram/hour (me evening shift every patch prior to apply R31's physician ord R31's physi	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 controls, and permit only authorized personnel to have access to the keys. 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 document review the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 5 of 5 residents (R59, R31, R8, R12, R32) reviewed with prescribed Fentanyl patches. In addition, the facility failed to ensure accurate pharmacy labeling was completed for 2 of 4 residents (R74 & R29) in the facility who receive insulin. Findings include: R59's physician order dated 7/16/15, indicated Fentanyl Patch every 72 hours, apply 12 microgram/hour (mcg/hr) transdermally, every evening shift every 3 day(s) for pain. Remove old patch prior to applying new patch. R31's physician order dated 7/22/15, indicated	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 controls, and permit only authorized personnel to have access to the keys. 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. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH OREFCIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 controls, and permit only authorized personnel to have access to the Keys. 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. 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Continued From page 16 controlled Arroy State Preprinciples to prevent potential drugs and preventing the page 12 p

F 431 Continued From page 17 transdermally, every 72 hours for compression fracture. R8's physician order dated 3/5/15, indicated Fentanyl Citrate Film apply 50 mcg/hr transdermally, one time a day, every 3 days, related to chronic pain syndrome. R12's physician order dated 6/15/15, indicated Fentanyl Patch every 72 hours apply 25 mcg/hr, R12's physician order dated 6/15/15, indicated Fentanyl Patch every 72 hours apply 25 mcg/hr, CONPLE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Wrong in that it says the DON stated the patch should be placed in the red sharps container. The DON stated it is to go in the Black Hazardous Waste container and this is the information that was given to the nursing staff prior to and after survey. The DON also told state staff that a paper signature had been put in place while the corporate office was working on a solution.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
HERITAGE LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470			245405	B. WING		07/2	23/2015
F 431 Continued From page 17 transdermally, every 72 hours for compression fracture. R8's physician order dated 3/5/15, indicated Fentanyl Citrate Film apply 50 mcg/hr transdermally, one time a day, every 3 days, related to chronic pain syndrome. R12's physician order dated 6/15/15, indicated Fentanyl Patch every 72 hours apply 25 mcg/hr, R12's physician order dated 6/15/15, indicated Fentanyl Patch every 72 hours apply 25 mcg/hr, COMPLÉ CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Wrong in that it says the DON stated the patch should be placed in the red sharps container. The DON stated it is to go in the Black Hazardous Waste container and this is the information that was given to the nursing staff prior to and after survey. The DON also told state staff that a paper signature had been put in place while the corporate office was working on a solution.					619 WEST SIXTH STREET		
transdermally, every 72 hours for compression fracture. Wrong in that it says the DON stated the patch should be placed in the red sharps container. The DON stated it is to go in the Black Hazardous Waste container and this is the information that was given to the nursing staff prior to and after survey. The DON also told state staff that a paper signature had been put in place while the corporate office was working on a solution.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
transdermally every 72 hours for pain. R32's physician order dated 7/9/15, indicated Fentanyl Citrate film, apply 12 mcg transdermally one time a day, every 2 days for pain. During interview on 7/23/15, at 10:18 a.m. licensed practical nurse (LPN)-E stated when placing a new Fentanyl patch on a resident, the old patch is first removed and the new dated patch is placed. LPN-E stated the old patch is cut up into small pieces and disposed of in the sharps container on the side of the med cart. LPN-E stated the nurse administering the patch signs in the electronic medication administration record (eMAR) for the administration of the new patch and destruction of the old patch. LPN-E stated this process is not witnessed or signed off by a second nurse. When interviewed on 7/23/15, at 10:53 a.m. LPN-B stated the used Fentanyl patch is cut up and put into the sharps container, and a second nurse witnessed the destruction, however, she was not aware of where the second nurse would sign to verify this was completed. D.) Bottles/pens not labeled were disposed of per policy and procedure. Insulin pens had a label on the box but not on the individual pens. Pens were sent back to pharmacy for individual labels. Education sent to the pharmacies used on 08/07/15. 2. Corrective Action as it relates to other residents: A.) All residents with orders for Fentanyl patch is cut up and destruction of the new patch and destruction of the new patch and destruction of the new patch and destruction, however, she was not aware of where the second nurse would sign to verify this was completed. S.) Bottles/pens not labeled were disposed of per policy and procedure. Insulin pens had a label on the box to not lividual labels. Education sent to the pharmacies used on 08/07/15. 2. Corrective Action as it relates to other residents: A.) All residents with orders for Fentanyl patch is cut up and patc	F 431	transdermally, ever fracture. R8's physician ord Fentanyl Citrate Fitransdermally, one related to chronic particles of transdermally ever transdermally ever R32's physician or Fentanyl Patch ever transdermally ever R32's physician or Fentanyl Citrate fill one time a day, ever During interview or licensed practical in placing a new Fenold patch is first repatch is placed. Lup into small pieces sharps container of LPN-E stated their signs in the electror record (eMAR) for patch and destruct stated this process by a second nurse when interviewed LPN-B stated the in and put into the shand put into the shand switnessed the was not aware of we sign to verify this well as the control of the state of the sign to verify this well as the sign to verify the sign to ver	er dated 3/5/15, indicated Im apply 50 mcg/hr time a day, every 3 days, pain syndrome. der dated 6/15/15, indicated ery 72 hours apply 25 mcg/hr, ry 72 hours for pain. der dated 7/9/15, indicated m, apply 12 mcg transdermally ery 2 days for pain. n 7/23/15, at 10:18 a.m. nurse (LPN)-E stated when tanyl patch on a resident, the moved and the new dated PN-E stated the old patch is cut as and disposed of in the on the side of the med cart. nurse administering the patch onic medication administration the administration of the new tion of the old patch. LPN-E is not witnessed or signed off the destruction, however, she where the second nurse would was completed.	F 431	wrong in that it says the DON state patch should be placed in the red container. The DON stated it is to the Black Hazardous Waste contains is the information that was given the nursing staff prior to and after The DON also told state staff that signature had been put in place we corporate office was working on a solution. D.) Bottles/pens not labeled were disposed of per policy and proced Insulin pens had a label on the boon the individual pens. Pens were back to pharmacy for individual labels. Education sent to the pharmused on 08/07/15. 2. Corrective Action as it relates to residents: A.) All residents with orders for Fengatch were reviewed and medical sheet updated in PCC. B.) Medication carts and refridges checked to make sure there were other medications out of complian 3. Re-occurrence will be prevented A.) Weekly QA for one month and monthly QA for three months. B.) Pharmacy check monthly on a going basis. C.) All QA results will be taken to committee for review and recommendations for further mond 4. The POC will be monitored by: nurses, Unit MAnagers, DON, Pharmacists.	sharps go in ainer and ven to survey. a paper chile the lure. ax but not sent macies o other entanyl ion s were no nce. d by: I then an on QA itoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245405	B. WING			07/	23/2015	
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER				619	REET ADDRESS, CITY, STATE, ZIP CODE WEST SIXTH STREET RK RAPIDS, MN 56470	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	LPN-C was unsure would document this would document the feet of nursing (Fentanyl patch show and disposed of in required to be with DON stated the factority a second nursur destruction of the Feomputer system is corporate office was solution. The facility policy tit 12/31/14, indicated from a resident the patch via the Black in the presence of a cut up prior to place both signatures will medical record. During observation LPN-E the North be one open Lantus (in control diabetes) promedical record it (name, date of label. There was no opened, or when it she believed the perform the hospital. On 7/23/15, at 10:2	d by two nurses, however, where the second nurse is was completed. on 7/23/15, at 11:45 a.m. DON) stated the used all be cut into small pieces the sharps container, which is essed by a second nurse. The ility had no documentation to	F 4	31				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245405	B. WING _		07/	23/2015
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470	_	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
in an opened box. R54's medical chabut no pharmacy later of the but no pha	n, unopened, in the refrigerator The pen had a label from rt with R54's information on it, abel. 44 a.m. LPN-C stated if an deived with no label on it, she ent label from the facility chart. 53 a.m. observation of the n LPN-B included a Novolog used to control diabetes) vial macy label on. Despite the vial date was noted as to when it iten it would expire. 15 7/23/15, at 11:04 a.m. DON 16 be dated when opened. 16 isulin that comes with residents 17 iten and put the date 18 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 19 ited Multi Dose Vials revision 19 ited Multi Dose Vials revision 10 address insulin pens or 10 CONTROL, PREVENT 11 ited Multi Dose Vials revision 11 ited Multi Dose Vials revision 12 ited Multi Dose Vials revision 13 ited Multi Dose Vials revision 14 ited Multi Dose Vials revision 15 ited Multi Dose Vials revision 16 ited Multi Dose Vials revision 17 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 19 ited Multi Dose Vials revision 10 ited Multi Dose Vials revision 10 ited Multi Dose Vials revision 11 ited Multi Dose Vials revision 12 ited Multi Dose Vials revision 13 ited Multi Dose Vials revision 14 ited Multi Dose Vials revision 15 ited Multi Dose Vials revision 16 ited Multi Dose Vials revision 17 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 19 ited Multi Dose Vials revision 10 ited Multi Dose Vials revision 16 ited Multi Dose Vials revision 17 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 19 ited Multi Dose Vials revision 10 ited Multi Dose Vials revision 11 ited Multi Dose Vials revision 12 ited Multi Dose Vials revision 13 ited Multi Dose Vials revision 14 ited Multi Dose Vials revision 15 ited Multi Dose Vials revision 16 ited Multi Dose Vials revision 17 ited Multi Dose Vials revision 18 ited Multi Dose Vials revision 18 ited Multi Dose Vials	F 44			8/31/15

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245405	B. WING		07/	23/2015	
	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP C 619 WEST SIXTH STREET PARK RAPIDS, MN 56470			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	in the facility; (2) Decides what p should be applied to (3) Maintains a recations related to in (b) Preventing Spreading (1) When the Infect determines that a reprevent the spreading isolate the resident (2) The facility must communicable disefrom direct contact direct contact will to (3) The facility must hands after each do hand washing is incorressional practice. (c) Linens Personnel must ha	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must interpreted the prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 4	41			
	by: Based on observa review, the facility f glucometer (device sugars) was appro resident use for 2 of	NT is not met as evidenced tion, interview, and document failed to ensure a multi use equilized for monitoring blood priately disinfected between of 2 residents (R74 & R29) the community glucometer extends to t		Heritage Living Center has established and maintains a Control Program designed t safe, sanitary and comfortal environment and to help predevelopment and transmiss and infection. 1. Corrective Action and 2. Caction as it applies to other	an Infection to provide a ble event the tion of disease Corrective		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245405	B. WING			07/2	23/2015
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER				6	TREET ADDRESS, CITY, STATE, ZIP CODE 19 WEST SIXTH STREET ARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(LPN)-A brought Riblood sugar reading glucometer, returned hallway, and wiped SuperSaniCloth, ho appear to be completely with the glucometer with the glucometer with the glucometer with the glucometer with the glucometer, which is resident. LPN-A veused to clean the glucometer, which is resident. LPN-A veused to clean the glucometer should. Review of the instrucontainer indicated treated surface to rand let air dry. When interviewed of LPN-B stated each community glucometer with the instruction of the cart of the community glucometer should.	6 a.m. licensed practical nurse 74 to her room, obtained a g with the multi use ed to the medication cart in the the glucometer with a swever, the glucometer did not letely wet after it was wiped. 10 a.m. LPN-A entered R29's a blood sugar with the same er which was used for R74, in the hallway, and wiped the e SuperSaniCloth, however, in did not appear to be r it was wiped. 17/22/15, at 11:31 a.m. LPN-A ation cart had a community is used for more than one erified the SuperSaniCloth is lucometer, which only needs be not need to remain wet for of time, however, the entire	F 4	441	A.) Nurse (LPN)A was counseled of improper cleaning and not following policy and procedure for cleaning the glucometer. She had training in No and training was repeated 07/23/15 correct procedure. B.) Nurse (LPN)C had also had training the ducation on 07/23/15 on the corresprocedure. C.) On 07/27/15 each nurse was given repeated education on 07/23/15 on the corresprocedure. C.) On 07/27/15 each nurse was given repeated the policy and procedure. Note that the policy is a reminder. D.) A step by step poster with proper cleaning was put on each medication as a reminder. E.)On 07/27/15 Policy and Procedure-written in an easier to follow form replaced in P&P manuals. Re-occurrence will be prevented A.) QA audit will be done weely for month by randomly asking staff the procedure and then monthly for the months. B.) Results will be taken to the QA committee to see if further action is needed. 4. The POC will be monitored by: PMHS,UM and DON. 5. Correction Date: 08/31/15.	y the ne v. 2014 on the ning ct ven a lurses inforce er on cart ire was nat and by:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245405	B. WING _		07/2	23/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 441	wiped off with the S was not aware if the time the glucomete being used again. When interviewed of director of nursing of the are to be cleaned be purple topped Superglucometer should ensure disinfection	ommunity glucometer is to be superSaniCloth, however, she ere was a certain amount of r was to remain wet before on 7/22/15, at 12:14 p.m. (DON) stated the glucometers etween each use with the erSaniCloth wipes, and the remain wet for 2 minutes to before the next patient use.	F 44	1		
F 456 SS=F	dated 5/23/11, indice the nurse is to wipe machine with a Ger solution wipe. If us SuperSaniCloth purbe in contact with the an additional applicancessary to keep minutes, and should 2 minutes.	eled Glucometer Cleaning stated after each patient use, down the glucometer emicidal wipe, or a 1:10 bleach ing a germicidal wipe (i.e the rple top), the wet solution must be machine for 2 minutes, and ation with a new wipe may be the machine moist for the 2 d be allowed to air dry after the NTIAL EQUIPMENT, SAFE DITION	F 45	6		8/31/15
	This REQUIREMENT by: Based on observative review, the facility for refrigerator equipm	cal, and patient care		It is the policy of Heritage Living (maintain all essential mechanical, electrical, and resident care equip safe operating condition.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION ULDING		(X3) DATE SURVEY COMPLETED	
		245405	B. WING		07/:	23/2015	
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER			(STREET ADDRESS, CITY, STATE, ZIP CODE 519 WEST SIXTH STREET PARK RAPIDS, MN 56470			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 456	routinely served me Findings include: During the initial kit p.m. the facility's m the exterior thermo temperature readin (F). However, a the cooler read 46 deg metal steam tray co top of a plastic mea cooler, just below th Both containers we one-half, to one inc was asked about th pans with water ins containers were pla unit to capture conc ceiling of the fridge why the temperatur cooler's exterior the unsure of the kitche C-A stated the facil (CDM) was aware of dripping beneath th cooler, however, no complete any repai During a follow-up 10:59 a.m. the exte facility's meat coole with a temperature interior thermomete a.m., after C-B and and closed the coo preparation, the exte to blink, with a tem	chen tour on 7/20/15, at 2:18 eat cooler was observed with meter blinking and a g of 43 degrees Fahrenheit ermometer located inside the rees F. Two medium-sized, ontainers were observed on al tray on the top shelf of the ne cooler's condensing unit. The noted with approximately the of water inside. Cook (C)-A ne purpose of the steam tray ide, and he stated the aced beneath the condensing densation dripping from the cooler's condensing from the condensity and stated he was unsure of the reading was blinking on the ermometer, and stated he was ens process to fix equipment. It it's certified dietary manager condensation had been use condensing unit of the meat othing had been done to	F 456	1. Corrective Action and 2. Correction as it relates to all resider A.) Filters changed, an outside added free-on to the fridge on CRefridge is working with proper temperatures now. 3. Re-occurrence will be prever A.) Added to TEIS program so maintenance will check coolers bi-monthly. B.) If temps are not within propedietary staff will notify maintenacan be fixed. C.)Staff to do QA on temps and CDM/Maintenance. Staff have leducated on proper temps and protocol. 4. The POC will be monitored by Administrator, Dietary Supervise Environmental Services Suervises. Correction Date: 08/31/2015	nts: company 07/23/15. nted by: er range nce so it I notify oeen notification by: or,		

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245405		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING _		07	/23/2015	
	PROVIDER OR SUPPLIER BE LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 456	atop a pink, plastic the cooler. The me shallow coating of were observed with water resting inside end of meal prepar thermometer contintemperature readin interior temperature interior thermomete temperature readin degrees F above the During interview on stated the facility's aware of problems stated the exterior on and off repeated outage, but she did blinking for several pressing the reset I supposed to resolv she tried to reset it thereafter. C-B stath had replaced a filte approximately two dripping/ condensa blinking thermometresponsible for con request slip for any repair. C-B confirm aware of these confirms aware of these confirms aware of these confirms aware outside of according to the same confirms and confirms aware outside of according to the same confirms are same confirms aware outside of according to the same confirms aware outside of according to the same confirms are same confirms aware outside of according to the same confirms are same confirms and confirms are same confirms.	m tray containers remained meal tray on the top shelf of al tray was noted with a water. The metal containers in greater than two inches of a. At 11:24 a.m., nearing the ation activities, the exterior nued to blink, with a g of 45 degrees F and an extending of 48 degrees F. The extending of 48 degrees F. The extending of 48 degrees F. The extending of the exterior thermometer. 17/22/15, at 11:24 a.m. C-B maintenance workers were with the meat cooler. C-B thermometer typically flashed dly when there was a power anot know why it had been weeks now. She stated that button on the cooler was the blinking, but each time at he blinking returned shortly the did the facility maintenance in the cooler/ condensing unit weeks prior, however, the tion continued, along with the ter. C-B stated all staff was inpleting a maintenance. It is kitchen equipment in need of ed the facility's CDM was	F 45	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
245405					/23/2015	
	PROVIDER OR SUPPLIER GE LIVING CENTER			STREET ADDRESS, CITY, STATE, Z 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 456	Logged temperatur acceptable ranges from 42 degrees F, During interview on CDM stated if a cocabove 41 degrees I the temperature late the cooler was not at the second temperature to herself or the factor of kitchen coolers she stated she was meat cooler had tendegrees F. The CD aware of concerns the condensing unit stated she was aware condensation from coolers had been at the coolers had been at the coolers had age the current concern whether facility mai current condensation from coolers. The CDM reto remain at 41 degrees food storage. During interview on 2:45 p.m. the facility stated he contacted company on 7/22/1 concerns with the facompany had arrive 7/23/15, and indicating the contacted company had arrive 7/23/15, and indicating the contacted contacted company had arrive 7/23/15, and indicating the contacted contacted contacted contacted contacted contacted contacted contacted contacted	es which were outside of for safe food storage ranged to 62 degrees F. 7/23/15, at 11:29 a.m. the oler temperature was noted as =, the staff were to re-check er in their shift, at a time when being frequently accessed. If ature reading remained above staff were to report the concernuitity's maintenance crew. The viewed the temperature logs about twice weekly, however, anot aware of the concerns the emperature readings above 41 DM also stated she was not of dripping condensation from the meat cooler. CDM	F4	56		

NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER BUSINMARY STATEMENT OF DEFICIENCIES FARK RAPIDS, MN 56470 [CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION] F 456 Continued From page 26 A facility policy addressing maintenance of kitchen equipment was requested, but was not provided. B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470 PROVIDERS PLAN OF CORRECTION CACH CORRECTION FOLICIES PARK RAPIDS, MN 56470 PROVIDERS PLAN OF CORRECTION COMPLETION DEFICIENCY) F 456 F 456 F 456			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DAT	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER (X4) ID PREFIX TAG F 456 Continued From page 26 A facility policy addressing maintenance of kitchen equipment was requested, but was not STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 456 A facility policy addressing maintenance of kitchen equipment was requested, but was not			245405	B. WING		07	/23/2015	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 456 Continued From page 26 A facility policy addressing maintenance of kitchen equipment was requested, but was not					619 WEST SIXTH STREET			
A facility policy addressing maintenance of kitchen equipment was requested, but was not	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
	F 456	A facility policy addi	ressing maintenance of	F 4	56			

PRINTED: 08/19/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 7	TIPI	E CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG (02 - 1960 BUILDING & 69, 90, 94, 2000		PLETED
		245405	B WING		<u> </u>	07/	22/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE LIVING CENTER				19 WEST SIXTH STREET		
	OLIMADY OT	ATTENDA OF DECIDIONS		P	ARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	тѕ	K 0	00			
	FIRE SAFETY						
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE PAGE OF THE CM	COC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
K	Minnesota Departn Fire Marshal division Heritage Living Cer found not in substate requirements for path Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			EDOO		
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	R THE FIRE SAFETY			EPOC		
	HEALTH CARE FIR						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

445 MINNESOTA STREET, SUITE 145

TITLE

(X6) DATE

Electronically Signed

08/11/2015

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:						DATE SURVEY COMPLETED	
		245405	B WING		07/	22/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the deficiency of the correct the actual, or provide a construction assisted living with a basement until 1960 building was all (1111) construction assisted living building the constructed to the constru	otate.mn.us m@state.mn.us RRECTION FOR EACH of INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. or title of the person rection and monitoring to ence of the deficiency. reveyed as one building: g Center is a 1-story building of the the the theorem of the the theorem of the theorem of the new the theorem of the theo	K 00				
	is separated form to fire barriers. In 199 constructed to the so building, was deter construction and is building with a 2-ho laundry addition was 1960 building, was II(111) construction	f Type II(111) construction and he 1960 building with 2-hour 0 the chapel addition was south of the of the 1960 mined to be of Type V(111) separated from the 1960 bur fire barrier. In 1994 the is added to the north of the determined to be of Type and is separated from the he new assisted living building					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS (X3) DAT CON			
		245405	B WING_		07/	22/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,	
HEDITAC	SELIVANO CENTED			619 WEST SIXTH STREET		
HERITAG	SE LIVING CENTER			PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 2	K 00	10		
	with 2-hour fire bard addition was added connect the nursing apartment building determined to be of is separated form to 2-hour fire barrier.	riers. In 2000 a main entrance I to the chapel addition to I home with the new to the south west, was I Type V (111) construction and the apartment building with a The building is divided into 5 I minute and 90 minute fire	Κ 00			
	protected in accord for the Installation of edition. The facility system with sleepin detection in commo doors that are held with NFPA 72 "The 1999 edition. Addit is provided in all roots."	and additions are sprinkler cance with NFPA 13 Standard of Sprinkler Systems 1999 has a manual fire alarm agroom smoke detection, on areas and at smoke barrier open, installed in accordance National Fire Alarm Code" cional automatic fire detection oms required by the Minnesota 07 edition and is monitored for rtment notification.				
	The facility has a cacensus of 50 at the	apacity of 64 beds and had a time of the survey.				
K 029 SS=D	NOT MET as evide NFPA 101 LIFE SA One hour fire rated	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD construction (with ¾ hour an approved automatic fire	K 02	9		8/31/15
	and/or 19.3.5.4 profithe approved auton option is used, the autonother spaces by sm	m in accordance with 8.4.1 tects hazardous areas. When hatic fire extinguishing system areas are separated from hoke resisting partitions and helf-closing and non-rated or				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 02 - 1960 BUILDING & 69, 90, 94, 2000 NS		E SURVEY PLETED
		245405	B. WING		07/	22/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029		tive plates that do not exceed bottom of the door are	K 02	29		
	Based on observation revealed that the far proper protection for areas located throu accordance with NF section 19.3.2.1. Tin the event of a first spread throughout the areas making them	FPA Life Safety Code 101 (00) his deficient conditions could e, allow smoke and flames to the effected corridors and untenable, which could e exiting capabilities for		1. Corrective Action: A.) Environmental Service Supervichaulked the two holes that were found fixed the door. 2. Re-occurrence will be prevented A.) QA audit will be done weekly for days and then monthly for 60 days ensure doors are in good condition. 3. The POC will be monitored by: Adminstrator and Environmental S Supervisor. 4. Correction Date: 08/31/15.	ound I by: r 30 to	
	07/22/2015, observ following conditions	veen 3:00 PM to 6:00 PM on ation revealed, that the were found affecting areas located within the				
	pipe that is located 2. The doors to sto	tration around the sprinkler in storage room N37, and brage rooms N37 and 107 did bositively latch into the door				
K 046 SS=D	Maintenance Super NFPA 101 LIFE SA	ces was confirmed by the visor. FETY CODE STANDARD of at least 1½ hour duration is	K 04	46		8/31/15

CENTE	49 LOK MEDICAKE	& MEDICAID SERVICES		UIVID I	VO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ING 02 - 1960 BUILDING & 69, 90, 94, 2000	DATE SURVEY COMPLETED
		245405	B WING		07/22/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 66470	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From pa provided in accorda	_	ΚO	46	
	Based on observa staff, the facility has emergency lighting accordance with Ni and 19.2.9.1. This residents, staff and emergency evacual Findings include: On facility tour betw 07/22/2015, during emergency battery maintenance documents of the Maintenance Stacility failed to consultation.	s not met as evidenced by: tions and an interview with s failed to ensure that has been tested in FPA LSC (00) Section 7.9.3, deficient practice could l visitors in the event of an tion during a power outage. veen 3:00 PM to 6:00 PM on the review of available back up exit lighting mentation and interview with upervisor revealed the that the duct the required Monthly 30 90 minute testing of the ergency lights.		1. Corrective Action: A.) Environmental Service Supervisor tested the emergency lighting for 90 minutes and found they were in good working order. 2. Re-occurrence will be prevented by: A.) Environmental Service Supervisor vitest emergency lighting monthly for 30 seconds and annually for 90 minutes. 3. The POC will be monitored by: Administrator and Environemntal Service Supervisor 4. Correction Date: 08/31/15.	
K 050 SS=F	Maintenance Supe NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between	retry code standard at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is empetent persons who are the leadership. Where drills are of 9 PM and 6 AM a coded by be used instead of audible	Κ¢	950	7/23/15

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CENTE	KS FUR WEDICARE	& MEDICAID SERVICES			MR NO.	0938-039
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 02 - 1960 BUILDING & 69, 90, 94, 2000 NS		E SURVEY PLETED
		245405	B. WING		07/	22/2015
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE LIVING CENTER			619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF1) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETIO DATE
K 050	Continued From pa	age 5	K 0	50		
	Based on review of interview, it was de to conduct fire drills Safety Code 101(0:12-month period. The affect how staff real improper reaction to of all residents. Findings include: On facility tour betw 07/22/2015, during maintenance documents of the Maintenance Staff residents.	is not met as evidenced by: if reports, records and staff itermined that the facility failed in accordance with NFPA Life 0), 19.7.1.2, during the last this deficient practice could ict in the event of a fire. by staff would affect the safety eveen 3:00 PM to 6:00 PM on the review of all available mentation and interview with supervisor it was revealed that conduct any fire drills in the ter within the last 12 months.		1. Corrective Action: A.)Facility did have documentation was found on 07/23/2015 showing dates/times of fire drills. Information unavilable to fire marshal at time of inspection. B.) Facility will continue to conduct drills in accordance with NFPA Life Code.Dietary Supervisor (Safety Committe) and Environmental Service Supervisor will both keep files with drills dates/times. 2. Re-occurrence will be prevented A.) QA will be done monthly by Environmental Service Supervisor Safety Committee to ensure fire dricompleted.	fire Safety rice fire by:	
	This deficient pract Maintenance Supe	ices was confirmed by the rvisor.		3. The POC will be monitored by: Administrator, Dietary Supervisor (Committee) and Environmental Ser Supervisor.		
	NFPA 101 LIFE SA	FETY CODE STANDARD	K 0	4. Correction Date: 07/23/15.		7/23/15
SS=F	activating door hold maintained, inspect	detectors, including those d-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3				
	This STANDARD is	s not met as evidenced by:				

Based on staff interview and a review of the

1. Corrective Action:

	TO I OIT MILLDION IT	A MEDICAID SERVICES			10.0000-000
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	` ′	G 02 - 1960 BUILDING & 69, 90, 94, 2000	DATE SURVEY COMPLETED
		245405	B, WING	_	07/22/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 66470	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 054	conducted that requestions with NF Code (99), Sec. 7-3 could affect all resident of the could not produce the	tation, the facility has not uired sensitivity testing of the in the fire alarm system in FPA 72 National Fire Alarm 3.2.1. This deficient practice dents, visitors, and staff. I ween 3:00 PM to 6:00 PM on the word the facility's available fire and testing documentation time of the inspection the	K 05	The facility did find paper work on 07/23/15 that the 2014 sensitivity testin of the smoke detectors was completed The paper work was not readily availabe when fire marshal was here for inspect The paper work for two year time spans will be kept in the same folder by the Environmental Service Supervisor. 2. Re-occurrence will be prevented by: Protection Systems out of Fargo, North Dakota will continue to do annual testin and paper work will be kept by ESS. 3. The POC will be monitored by: Administrator and Environmental Service Supervisor.	le on. s
K 056 SS=D	Maintenance Super NFPA 101 LIFE SA If there is an autom installed in accorda for the Installation of provide complete or building. The syste accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the syste systems are equipped to the systems are equipped to the systems.	ratic sprinkler system, it is not with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler sed with water flow and tamper electrically connected to the	K 05	4. Corrective Date: 07/23/15.	8/31/15

	TO TOTAL MILEDION WILL	& WEDICAID SERVICES		CIVID	140, 0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	G 02 - 1960 BUILDING & 69, 90, 94, 2000	O) DATE SURVEY COMPLETED
		245405	B. WING_		07/22/2015
	PROVIDER OR SUPPLIER BE LIVING CENTER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 66470	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 056	Based on observation found that the autoinstalled and maint NFPA 13 the Stand Sprinkler Systems the sprinkler Systems the sprinkler system (99) could allow system a decrease capability in the even would affect the restacility. Findings include: On facility tour betw 07/22/2015, observing auges that are locally system have not be	s not met as evidenced by: tions and staff interview, it was matic sprinkler system is not ained in accordance with ard for the Installation of (99). The failure to maintain in compliance with NFPA 13 stem being place out of service in the fire protection system ent of an emergency that sidents, visitors and staff of the even 3:00 PM to 6:00 PM on rations have revealed that the ated on the fire sprinkler even recalibrated or replaced ars, the last service for the	K 056	1. Corrective Action: A.)Gauges that are located on the fire sprinkler system will be recalibrated at replaced by outside company. 2. Re-occurrence will be prevented by A.) QA will be done by Environmental Service Supervisor to ensure the sprin system is maintained in accordance w NFPA standards. B.) Gauges added to Tels program to remind ESS to conduct QA. 3. The POC will be monitored by: The Administrator and the Environmental Service Supervisor. 4. Correction date: 08/31/15.	nd : ukler nith
K 062 SS=D	Maintenance Super NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	ices was confirmed by the rvisor. FETY CODE STANDARD c sprinkler systems are ained in reliable operating aspected and tested .6, 4.6.12, NFPA 13, NFPA 25,	K 062	2	7/23/15
	Based on docume with staff, the facilit and maintain the au	s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00),		Corrective Action: A.) The 2014 report was not in file whe Fire Marshal was here for inspection. Paper work found 07/23/15 and is now.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS		(X3) DATE SURVEY COMPLETED	
245406		245405	B, WING		07/22/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 062	of Sprinkler System for the Inspection, Water Based Fire F deficient practice disprinkler system is fully operational in negatively affect resemble. On facility tour betw 07/22/2015, a revieinterview with the I revealed the facility quarterly fire sprink	14.6.12, NFPA 13 Installation is (99), and NFPA 25 Standard festing and Maintenance of Protection Systems, (98). This is one not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors. If all the fire and could sidents are required by NFPA	Kod	file. An outside company, NOVA, or the tests. The tests had been compas required. 2. Re-occurrence will be prevented A.) NOVA will continue to do fire springled that are required by NFPA standard B.) Environmental Supervisor will or to ensure the test is completed and keep all paper work in file together 3. The POC will be monitored by Administrator and Environmental Supervisor 4. Correction Date: 07/23/15.	l by: prinkler test ds. do QAs d will	
K 067 SS=F	Maintenance Super NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with specifications. 19.5.2.2 This STANDARD is Based on document interview, the fire/si been maintained in requirements of NF	FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	K 06	Corrective Action: A.) Environmental Services Depart did testing/inspection of the fire ansamoke dampers on 07/29/15.		8/31/15

		A WILDIOAD SERVICES			011101101	0930-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION BING 02 - 1960 BUILDING & 69, 90, 94, 2000 DNS	(X3) DATE SURVEY COMPLETED		
		245405	B, WING		07/	22/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MN 56470				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
K 067	Continued From pa	_	K	067			
		tion to negatively affect the nts, staff and visitors in the		 Re-occurrence will be prevent A.) QA will be done by ESS and TELS program to remind staff to the task. B.) Proper paper work will be ke 	added to complete		
	Findings include:			record current.			
	07/22/2015, it was the facility's fire and	veen 3:00 PM to 6:00 PM on revealed during the review of d smoke damper umentation and was confirmed		The POC will be monitored by Administrator and the Environment Service Supervisor.			
	by interview with th the facility had faile verifying that the fir	e Maintenance Supervisor that d to provide documentation e and smoke dampers have ted within the last 4 years.		4. Correction Date: 08/31/15.			
	This deficient pract Maintenance Super	ices was confirmed by the rvisor.					
				4			
	14						



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 3, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5405025

Dear Mr. Hansen:

The above facility was surveyed on July 20, 2015 through July 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Heritage Living Center August 3, 2015 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner at (320) 223-7343 or email: jessica.sellner@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,

Mark Weath

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

PRINTED: 08/20/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00288	B. WING		07/2	3/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	, ,,,,	.,	
HERITAGE LIVING CENTER			SIXTH STR PIDS, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/11/15

TITLE

STATE FORM 6899 5ENO11 If continuation sheet 1 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00288	B. WING		07/	23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HERITAG	HERITAGE LIVING CENTER 619 WES PARK RA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. Is necessary for State necessary for State enter the word "corn text. You must then State licensure proceedings of the Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of computer of the Statement	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the tent of Health. 2, 7/23, 2015, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting and to correction Orders using an umbers have been ota state statutes/rules for the ent of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE	2 000			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00288	B. WING		07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HERITAG	E LIVING CENTER		SIXTH STF PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			8/31/15
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on interview facility failed to coor	and document review, the rdinate dialysis services for 1 reviewed for dialysis.		See POC under F282 and F309. Correction Date: 08/31/15.		
	Findings include:					
	R54 was admitted t	o the facility on 7/2/15.				
	7/8/15, noted R54 v diagnosis including (ESRD), diabetes n	inimum Data set (MDS) dated vas cognitively intact, had end stage renal disease nellitus, anemia, and eceived dialysis treatment at				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00288	B. WING		07/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
HERITAC	SE LIVING CENTER		SIXTH STR			
II EIIII A		PARK RAI	PIDS, MN 5	6470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	instructed staff: -Daily weights shou scale, amount of closame time with eaction and the same time and t	ould never be taken on an ains a dialysis access or may access. and a left upper arm fistula of an artery to a vein, used to treatment), and staff was to access daily, which included on in the assess, listening for ope in the access, and ess, warmth or signs of and bandages may be hours following dialysis.				
	7/2/15, indicated the complications relate and receiving hemorand Friday. Under the plan indicated R54 stage 4, and interversion of the plan indicated R54 stage 4, and interversion of the pressure in arm with had a fistula, and the where the access when with the access when it is including redness, so the plant of t	report as needed any infection to access site swelling, warmth, or drainage,				

Minnesota Department of Health

STATE FORM 5699 5ENO11 If continuation sheet 4 of 28

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		00288	B. WING		07/23/2015		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	J/ Z U 1J	
	SE LIVING CENTER	619 WEST	SIXTH STF	REET			
			PIDS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 4	2 830				
	sight.						
	practical nurse (LPN R54's access site of stated she did not derecord. LPN-A state weighed three times looked in R54's meawas only two weighes admission on 7/2/15. During interview on stated staff do not learn from dialysis. Covered by gauze and she removes it	7/22/15, at 8:52 a.m. R54 ook at her access site on her . R54 stated her fistula is and tape when leaving dialysis, herself after she returns to ted staff at the facility have					
	nursing assistant (N special related to ob R54, and there was	on 7/22/15, at 8:59 a.m. NA)-E stated there was nothing ortaining a blood pressure on a nothing special related to the eatments she should be					
	LPN-E stated when would just ask how completed monthly LPN-E verified there	on 7/23/15, at 10:07 a.m. R54 returns from dialysis she she is doing, and weights are unless ordered otherwise. e is no documentation to ss site is being monitored.					
	registered nurse (R "Missing information to the special cares dialysis patient. RN	on 7/23/15, at 2:21 p.m. N)-B stated R54 had some, n" in her medical chart related staff needed to provide for a I-B verified staff should be ents weight and vital signs					

Minnesota Department of Health

STATE FORM 5699 5ENO11 If continuation sheet 5 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00288	B. WING	B. WING		3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
HERITAG	GE LIVING CENTER		T SIXTH STR PIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
		ould be an order and direction e access site when R54 s treatment.				
	stated there was no know regarding obt R54. NA-D went to	on 7/23/15, at 8:51 a.m. NA-D othing special staff needed to aining a blood pressure on check R54's care plan, and o mention about precautions od pressure.				
		lers from 7/2/15 - 7/23/15, for weights other than ol.				
	record, and treatme July 2015, failed to	edication administration ent administration record, for identify an order for special nt related to pre or post essment.				
	record from 7/2/15 7/8/15, 7/13/15 pre were noted, howeve	ogress notes from R54's - 7/23/15, indicated 7/6/15, and post dialysis weights er, there were no other maining days of dialysis.				
	Facility policy relate but none provided.	ed to dialysis was requested				
	The Director of Nur staff to comprehens interventions to ens care in a manner to well-being. A monit established in order	fective care plan interventions				

Minnesota Department of Health

STATE FORM 5899 5ENO11 If continuation sheet 6 of 28

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00288	B. WING		07/2	07/23/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•		
HERITAGE LIVING CENTER			SIXTH STR PIDS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 6	2 830				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty one					
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			8/31/15	
	comprehensive reshome must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,					
	by: Based on observati review, the facility fa with nail care and re	ent is not met as evidenced on, interview, and record ailed to provide assistance emoval of facial hair for 1 of 2 o were dependent upon staffing.		See POC under F312. Correction Date: 08/31/15.			
	Findings include:						
	record dated 4/14/0	noted on the admission 8, included senile dementia, on of the retina, and					
	7/5/15, indicated Runderstood, had lor problems, required staff for transferring unit, dressing, toilet bathing, and supervision	ng and short term memory extensive assistance of one plants, locomotion on and off the ing, personal hygiene and vision for eating.					
	R14's plan of care,	dated 7/10/15, directed staff					

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00288	B. WING		07/	23/2015	
RITAGE LIVING CENTER 619 W	ADDRESS, CITY, S EST SIXTH STR RAPIDS, MN 56	EET			
(4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
to give clear explanation of all care activities pri to and during each contact, and if R14 resists assistance with activities of daily living (ADL), staff were to reassure R14, leave, and return 5-minutes later and try again. The plan of care further indicated R14 had an activities of daily living (ADL) self-care performance deficit with interventions to, "Check nail length and trim and clean on bath day and as necessary." During an observation on 7/21/15, at 1:30 p.m., R14 was sitting in the wheelchair in the dining room. R14 had long, jagged fingernails, with a dark brown substance noted under the nails, especially on the right hand. R14 also had several one-half inch facial hairs on the upper li and under the chin. During observation on 7/22/15, at 2:29 p.m., R1 was again sitting in the dining room, and the facial hair and long, dirty fingernails remained. During an observation on 7/23/15, at 8:18 a.m., R14 was sitting at the table in the dining room, eating breakfast. R14's fingernails remained for jagged, and dirty, and the facial hair remained of the upper lip and chin. During an interview on 7/23/15, at 8:28 a.m., nursing assistant (NA)-B stated all staff were responsible to ensure residents requiring assistance with grooming were clean shaven at their nails were cared for. NA-B stated nail care was usually performed when the residents had bath, and as needed. NA-B stated R14 had received a bed bath on 7/22/15. NA-B was unsure why R14 did not have the nails trimmed facial hair shaved, but stated if R14 refused, stawould typically reapproach her and she would	p 4 ag, and a or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00288	B. WING		07/2	23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
HERITAC	GE LIVING CENTER		T SIXTH STR APIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 8	2 920			
	NA-C stated she ha 7/22/15, and verified removal were not co	on 7/23/15, at 8:50 a.m., ad given R14 a bed bath on d R14's nail care and hair ompleted after giving the bath h NA-C could not indicate				
	family member (FM consistently provide R14's nail care and stated, "I mentioned again." FM-A stated nursing (DON) a few better about ensurin however, lately she completed. FM-A stated facial hair, adding, 'herself. I think the faconsistent provides and the stated facing of the stat	on 7/23/15, at 9:57 a.m., a)-A indicated the staff did not be grooming assistance for facial hair removal, and dit a couple of weeks ago as she had talked to director of womenths ago and staff got ng the cares were complete, felt the cares were not being tated R14 used to pull out the [R14] always took care of that acial hair bothered [R14] when of her surroundings."				
	DON stated staff ar registered nurse or having trouble com a resident refuses of	on 7/23/15, at 10:39 a.m., e instructed to go to the to the unit manager if they are pleting cares for a resident. If eares, staff are trained to wait nutes later to try again, or to e try.				
		providing grooming services for ton staff was requested but				
	The Director of Nur monitor personal ca provide education for	THOD OF CORRECTION: sing or designee could ares provided to residents and or staff regarding personal r of Nursing or designee could				

Minnesota Department of Health

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00288	B. WING		07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
HERITAGE LIVING CENTER			SIXTH STR PIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 9	2 920			
	audit and monitor fo	or compliance.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
21015	MN Rule 4658.0610 Requirements- Sar	Subp. 7 Dietary Staff nitary conditi	21015			8/31/15
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.					
	by: Based on observati review, the facility for refrigerators maintal controls for the safe facility also failed to levels for sanitizatio equipment cleaned three-compartment	sink. This had the potential to ts who were routinely served		See POC under F371. Correction Date: 08/31/15.		
	Findings include:					
	p.m. the facility's me the exterior thermon temperature reading (F). However, a the cooler read 46 degr was unsure of why blinking on the cool Also during the tour	chen tour on 7/20/15, at 2:18 eat cooler was observed with meter blinking and a g of 43 degrees Fahrenheit rmometer located inside the rees F. Cook (C)-A stated he the temperature reading was er's exterior thermometer. The facility's kitchen was with both a three-compartment				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY
71112 1 27111	or confidence	ISEITTII TOTTI TOTTI TOTTI ETT.	A. BUILDING:		00.11.11	
		00288	B. WING		07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HERITAC	GE LIVING CENTER		SIXTH STR PIDS, MN 56			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
21015	Continued From pa	ge 10	21015			
	sink with chemical sanitization, and a dish washer for high temperature sanitization.					
		kitchen tour on 7/22/15, at rior thermometer of the				
	facility's meat coole	r was observed as blinking,				
		reading of 37 degrees F. The read 40 degrees F. At 11:10				
	a.m., after C-B and	dietary aide (DA)-A opened				
		er several times during meal erior thermometer continued				
		perature reading of 42 degrees				
	At 11:24 a.m., near	nometer read 45 degrees F. ing the end of meal				
		s, the exterior thermometer				
		with a temperature reading of an interior temperature reading				
		ne interior thermometer				
		ed temperature readings of e degrees F above the exterior				
		g interview at this time, C-B				
		hermometer typically flashed lly when there was a power				
		not know why it had been weeks now. She stated				
	pressing the reset b	outton on the cooler was				
		e the blinking, but each time the blinking returned shortly				
		firmed the facility's certified				
		CDM) was aware of these				
		was responsible for review of s for the facility's kitchen				
	coolers and freezer	S.				
		ow-up tour, the facility's				
		sink was observed filled with ions, with a dish washing cart				
	holding one plastic	cutting board, two Dycem (a				
	manufacturer of no	n-slip products) mats, and a located next to the sink. DA-B				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00288	B. WING		07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HERITAG	HERITAGE LIVING CENTER 619 WES PARK RA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	stated most dishes through the dish was anitization, but adoplastic mats were sthree-compartment temperature dish w Dycem mats. At the mats were observe area, placed atop in cups turned upside cups pressed again were left to air dry. The three-compartment compartment chemical levels, ho to locate any test strip she was typically rethree-compartment chemical levels, ho to locate any test strip since the beginning facility's CDM was available and stated been having a difficult sanitization compart facility. Review of REFRIG SHEETS for the face 6/17/15, through 7/10 outside of acceptate (31%) of temperature of 62 con 6/19/15, the day 42 degrees F and the temperature of 43 con first personner to the sanitization compart facility.	and equipment were run asher for high temperature ded that items such as the olely cleaned using the sink because the high asher melted the plastic/ at time, several weaved plastic d being used in the dish drying heal trays, with freshly cleaned down, with the lips of the list the mats while the cups DA-B stated the chemicals for hent sink were tested routinely er, DA-B was unable to locate as At 11:30 a.m., DA-C stated asponsible for testing the sink solution for the required wever, she had been unable trips for testing the chemicals of the month. She stated the aware there were no test strips d she believed the CDM had sult time getting the chemical my to send test strips to the ERATOR FREEZER TEMP cility's meat cooler from 22/15, temperatures were ole ranges for 22 out of 71 are recording opportunities, sing: ening shift logged a degrees F. y shift logged a temperature of the evening shift logged a	21015			

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
	00288			07/2	3/2015
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, S	STATE, ZIP CODE		0,2010
HERITAGE LIVING CENTER		SIXTH STR			
HERITAGE LIVING CENTER	PARK RAF	PIDS, MN 56	6470		
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015 Continued From page 1	12	21015			
On 6/22/15, the day shi 48 degrees F and the e temperature of 51 degrees Gn 6/23/15, the day shi 45 degrees F. On 6/27/15, the day shi 43 degrees F. On 6/28/15, the day shi 45 degrees F. On 7/2/15, the evening of 52 degrees F. On 7/6/15, the day shift 48 degrees F and the e temperature of 42 degreency on 7/7/15, the day shift 42 degrees F. On 7/8/15, the evening of 50 degrees F. On 7/8/15, the evening of 42 degrees F. On 7/12/15, the day shift 42 degrees F. On 7/12/15, the day shift 42 degrees F and the e temperature of 44 degreency on 7/13/15, the evening temperature of 42 degreency on 7/14/15, the day shift 48 degrees F. On 7/16/15, the day shift 42 degrees F. On 7/16/15, the day shift 42 degrees F. On 7/17/15, the day shift 42 degrees F. On 7/18/15, the day shift 42 degrees F. On 7/18/15, the day shift 42 degrees F. The logs also lacked regrees of 71 (24%) of opporture logged did not differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the same shift and the differentient exterior thermometer were regreased to the day shift and the differentient exterior thermometer were regreased to the same shift and the day shift and t	ift logged a temperature of evening shift logged a rees F. ift logged a temperature of is shift logged a temperature of evening shift logged a temperature of it logged a temperature if logged a temperature if logged a temperature of evening shift logged a temperature of evening shift logged a temperature of it logged a temperature of its logged a tempe	21015			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONTECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COIVII	LLILD
		00288	B. WING		07/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
UEDITA.	SELIVING CENTER	619 WEST	SIXTH STR	REET		
HERITAGE LIVING CENTER PARK RA			PIDS, MN 50	6470		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 13	21015			
	temperatures were read from the exterior thermometer.					
	facility's three-comp through 7/22/15, ide available for 30 of 6 with entries lacking (52%) entry opportup parts-per million (property operation of the supper meal, was the recorded during this of the supper meal, was the recorded during this of the supper meal, was the recorded during this of the supper meal, was the recorded during this of the supper meal, was the reading the supper meal of the supper meal	7/23/15, at 11:29 a.m. the ere to reference the interior olers/ freezers when logging				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	` '		SURVEY LETED
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		LLILD
		00288	B. WING		07/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HERITAC	BE LIVING CENTER		SIXTH STR PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	C-C had not located testing of the three-stated the facility's was evaluated mon supplier) and she retempted told her when the k strips, but she had date. The facility's CLEAR COMPARTMENT Significant directed chemical stested periodically the and to ensure three preserved in clean SUGGESTED MET The certified dietary could ensure all state sanitization procedule equipment for cheir CDM could monitor compliance.	d test strips for her routine compartment sink. CDM chemical sanitization system of the chemical eviewed the DISHWASHER lily. CDM stated C-C typically itchen had run out of test not been informed of this to	21015			
21025	MN Rule 4658.061	5 Food Temperatures	21025			8/31/15
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co	us food must be maintained at heit (four degrees centigrade) grees Fahrenheit (66 degrees re. "Potentially hazardous and subject to continuous time ontrols in order to prevent the regrowth of infectious or				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00288	B. WING		07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HERITAG	GE LIVING CENTER		T SIXTH STF PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21025	Continued From pa	ge 15	21025			
	toxigenic microorga	anisms.				
	by: Based on observati review, the facility for refrigerator equipment the potential to affe	on, interview, and document ailed to maintain the kitchen ent in good repair. This had ct all 46 residents who were eals from the facility kitchen.		See POC under F371 and F456. Correction Date: 08/31/2015.		
	Findings include:					
	p.m. the facility's m the exterior thermo temperature readin (F). However, a the cooler read 46 degrated steam tray cotop of a plastic measure cooler, just below the Both containers we one-half, to one included was asked about the pans with water inscontainers were plaunit to capture conceiling of the fridge why the temperatur cooler's exterior the unsure of the kitche C-A stated the facili (CDM) was aware of dripping beneath the cooler, however, no complete any repair	kitchen tour on 7/22/15, at				
	10:59 a.m. the exte	rior thermometer of the r was observed as blinking				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:		
		00288	B. WING		07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HERITAG	GE LIVING CENTER		SIXTH STR PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21025	with a temperature interior thermomete a.m., after C-B and and closed the coopreparation, the exito blink, with a temperature interior thermometer. The two metal stea atop a pink, plastic the cooler. The meshallow coating of were observed with water resting inside end of meal preparthermometer continterior temperature readin interior temperature readin degrees F above the During interview on stated the facility's aware of problems stated the exterior to on and off repeated outage, but she did blinking for several pressing the reset is supposed to resolv she tried to reset it, thereafter. C-B stat had replaced a filte approximately two dripping/ condensa blinking thermomet responsible for correquest slip for any	reading of 37 degrees F. The er read 40 degrees F. At 11:10 dietary aide (DA)-A opened ler several times during meal terior thermometer continued perature reading of 42 degrees mometer read 45 degrees F. m tray containers remained meal tray on the top shelf of all tray was noted with a water. The metal containers a greater than two inches of e. At 11:24 a.m., nearing the ation activities, the exterior nued to blink, with a g of 45 degrees F and an ereading of 48 degrees F. The er consistently revealed gs of approximately three he exterior thermometer. 17/22/15, at 11:24 a.m. C-B maintenance workers were with the meat cooler. C-B thermometer typically flashed ally when there was a power of not know why it had been weeks now. She stated that button on the cooler was the blinking, but each time the blinking returned shortly the ded the facility maintenance or in the cooler/condensing unit weeks prior, however, the tion continued, along with the ter. C-B stated all staff was apleting a maintenance kitchen equipment in need of ed the facility's CDM was	21025			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00288	B. WING		07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HERITAC	SE LIVING CENTER		T SIXTH STR PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	Review of REFRIGISHEETS for the factor of 6/17/15, through were outside of accomplete acceptable ranges of from 42 degrees from 43 degrees from 45 degrees from 46 degrees from 47 degrees from 47 degrees from 48 degrees fro	ERATOR FREEZER TEMP cility's meat cooler identified gh 7/22/15, temperatures eptable ranges for 22 out of ature recording opportunities. es which were outside of for safe food storage ranged to 62 degrees F. 7/23/15, at 11:29 a.m. the older temperature was noted as F, the staff were to re-check er in their shift, at a time when being frequently accessed. If ature reading remained above taff were to report the concern ility's maintenance crew. The viewed the temperature logs about twice weekly, however, not aware of the concerns the imperature readings above 41 pm also stated she was not of dripping condensation from the meat cooler. CDM	21025	DEFICIENCY)		
	During interview on 2:45 p.m. the facility stated he contacted	7/23/15, at approximately 's director of maintenance I a refrigeration repair 5, to address the above noted				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COM			TE SURVEY MPLETED	
			A. BUILDING:				
		00288	B. WING		07/2	3/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
HERITAC	E LIVING CENTER		T SIXTH STR PIDS, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21025	Continued From pa	ge 18	21025				
	company had arrive 7/23/15, and indicate low on Freon (a gas refrigerant).	acility's meat cooler. The ed to repair the cooler on ted the meat cooler had been s or liquid used as a					
		was requested, but was not					
	SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) or designee could ensure staffs are retrained on safe food handling practices, particularly related to the safe temperature of food in the refrigerators. The CDM or designee could develop monitoring systems to ensure ongoing compliance.						
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			8/31/15	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	by: Based on observati review, the facility fa glucometer (device sugars) was appropresident use for 2 o	on, interview, and document ailed to ensure a multi use utilized for monitoring blood oriately disinfected between f 2 residents (R74 & R29) the community alucometer		See POC under F441. Correction Date: 08/31/15.			

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 619 WEST SIXTH STREET PARK RAPIDS, MM 56470 SUMMARY STATEMENT OF DEPOLEXCIES TAG SUMMARY STATEMENT OF DEPOLEXCIES FREED PARK RAPIDS, MM 56470 PREPARE CACH DEPOLEXCIES SO THE APPROPRIATE DEPOLEXCIES THAN 56470 CONTINUED CACH DEPOLEXCIES DESTRUCTIONS OF PREPARE TO THE APPROPRIATE DATE CONTINUED FOR THE APPROPRIATE DATE TAG 21375 Continued From page 19 from the North Back medication cart. Findings include: On 7/22/15, at 11:06 a.m. licensed practical nurse (LPN)-A brought RAP to her room, obtained a blood sugar reading with the mutil use glucometer, returned to the medication cart in the hallway, and wiped the glucometer with a SuperSamiCloth, however, the glucometer which was used for R74, returned to the cart in the hallway, and wiped the glucometer withich was used for R74, returned to the cart in the hallway, and wiped the glucometer within the SuperSamiCloth, however, the glucometer again did not appear to be completely wet after it was wiped. During interview on 7/22/15, at 11:31 a.m. LPN-A stated each medication cart had a community glucometer, which is used for more than one resident. LPN-A verified the SuperSamiCloth is used to clean the glucometer, which only needs to be wiped, and does not need to remain wet for any certain amount of time, however, the entire glucometer, which be wiped down. Review of the instructions on the SuperSaniCloth container indicated when wiped, to allow the treated surface to remain wet for a full 2 minutes, and let air dry. When interviewed on 7/22/15, at 11:55 a.m. LPN-B stated each medication cart had a community glucometer, which for a full 2 minutes, and let air dry.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
RENTAGE LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES TAG DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION BY CREATED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CANCELLER OF CHOSS-REFERENCED TO THE APPROPRIATE DATE OF CHOSS-REFERENCED TO THE APPROPENT OF CHOSS-REFERENCED TO THE APPROPRIATE DATE OF CHOSS-REFERENCED TO THE APPROPRIATE DATE OF CHOSS-REFERENCED TO THE APPROPER TO THE APPROPENT OF CHOSS-REFERENCED TO THE APPROPENT OF CHOSS-REFE			00288	B. WING		07/2	23/2015
PARK RAPIDS, MN 56470 PROVIDER'S PLAN OF CORRECTION (PAREDULATIVE MEDIAL TIME APPROPRIATE COMPLET IN A CO	NAME OF I	PROVIDER OR SUPPLIER					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 19 from the North Back medication cart. Findings include: On 7/22/15, at 11:06 a.m. licensed practical nurse (LPN)-A brought R74 to her room, obtained a blood sugar reading with the multi use glucometer, returned to the medication cart in the hallway, and wiped the glucometer with a SuperSaniCloth, however, the glucometer did not appear to be completely wet after it was wiped. On 7/22/15, at 11:20 a.m. LPN-A entered R29's room and obtained a blood sugar with the same multi use glucometer with the SuperSaniCloth, however, the glucometer with the glucometer with the SuperSaniCloth, however, the glucometer with the SuperSaniCloth, however, the glucometer with the SuperSaniCloth, however, the glucometer with the SuperSaniCloth is used to clean the glucometer, which only needs to be wiped, and does not need to remain wet for any certain amount of time, however, the entire glucometer should be wiped down. Review of the instructions on the SuperSaniCloth container indicated when wiped, to allow the treated surface to remain wet for a full 2 minutes, and let air dry. When interviewed on 7/22/15, at 11:55 a.m. LPN-B stated each medication cart had a community glucometer should be wiped down.	HERITAC	SE LIVING CENTER					
from the North Back medication cart. Findings include: On 7/22/15, at 11:06 a.m. licensed practical nurse (LPN)-A brought R74 to her room, obtained a blood sugar reading with the multi use glucometer, returned to the medication cart in the hallway, and wiped the glucometer with a SuperSaniCloth, however, the glucometer did not appear to be completely wet after it was wiped. On 7/22/15, at 11:20 a.m. LPN-A entered R29's room and obtained a blood sugar with the same multi use glucometer which was used for R74, returned to the cart in the hallway, and wiped the glucometer with the SuperSaniCloth, however, the glucometer again did not appear to be completely wet after it was wiped. During interview on 7/22/15, at 11:31 a.m. LPN-A stated each medication cart had a community glucometer, which is used for more than one resident. LPN-A verified the SuperSaniCloth is used to clean the glucometer, which only needs to be wiped, and does not need to remain wet for any certain amount of time, however, the entire glucometer should be wiped down. Review of the instructions on the SuperSaniCloth container indicated when wiped, to allow the treated surface to remain wet for a full 2 minutes, and let air dry. When interviewed on 7/22/15, at 11:55 a.m. LPN-B stated each medication cart had a community glucometer, which should be	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETE
between patient use to ensure appropriate disinfection.	21375	from the North Back Findings include: On 7/22/15, at 11:0 (LPN)-A brought R7 blood sugar reading glucometer, returned hallway, and wiped SuperSaniCloth, ho appear to be completely and obtained multi use glucometer returned to the cart glucometer with the glucometer with the glucometer aga completely wet afte. During interview on stated each medical glucometer, which is resident. LPN-A verused to clean the glucometer should be wiped, and do any certain amount glucometer should. Review of the instruction of the completely wiped and let air dry. When interviewed of LPN-B stated each completely wiped and between patient used between patient used between patient used.	k medication cart. 6 a.m. licensed practical nurse 74 to her room, obtained a g with the multi use 8d to the medication cart in the 8d to the medication cart in the 9d to the medication cart in the 10d the 9d to the medication cart in the 10d the 9d the 9d the 10d the	21375			

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
ANDILAN	OF COTTLECTION	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		LLILD	
		00288	B. WING		07/2	3/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
HERITAG	E LIVING CENTER		SIXTH STR PIDS, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 20	21375				
	LPN-C stated the conviped off with the S was not aware if the time the glucomete being used again.	on 7/22/15, at 12:00 p.m. ommunity glucometer is to be superSaniCloth, however, she ere was a certain amount of r was to remain wet before					
	are to be cleaned b purple topped Supe glucometer should	(DON) stated the glucometers etween each use with the erSaniCloth wipes, and the remain wet for 2 minutes to before the next patient use.					
	The facility policy titled Glucometer Cleaning dated 5/23/11, indicated after each patient use, the nurse is to wipe down the glucometer machine with a Germicidal wipe, or a 1:10 bleach solution wipe. If using a germicidal wipe (i.e the SuperSaniCloth purple top), the wet solution must be in contact with the machine for 2 minutes, and an additional application with a new wipe may be necessary to keep the machine moist for the 2 minutes, and should be allowed to air dry after the 2 minutes.						
	The Director of Nur staff and perform a control techniques	THOD OF CORRECTION: sing or designee could train udits to ensure infection are being followed. R CORRECTION: Twenty one					
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis	21426			8/31/15	
	(a) A nursing home	e provider must establish and					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00000	B. WING		07/02/22/2	
		00288			07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HERITAC	SE LIVING CENTER		T SIXTH STF PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implement	nensive tuberculosis orgam according to the most of infection control guidelines of States Centers for Disease tion (CDC), Division of eation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis on that covers all paid and contractors, students, interes. The Department of extechnical assistance entation of the guidelines.	21426			
	by: Based on interview facility failed to ensi (registered nurse (F (LPN)-D, nursing as (KA)-A, and activitie adequately screene to having direct con addition, the facility residents (R59) had read after the secon Findings include: RN-A's first step TS 6/9/15. RN-A starte 6/10/15. RN-A's first negative on 6/11/15	and documentation review the ure 5 of 5 employees RN)-A, licensed practical nurse ssistant (NA)-A, kitchen aide es assistant (A)-A), were ed for tuberculosis (TB), prior stact with residents. In failed to ensure 1 of 5 d a tuberculosis skin test (TST) and step was completed. ST was administered on ed with direct resident care on st step TST was read as 5. RN-A second step TST was 21/15, however, the second		It is the policy and procedure of He Living Center to make sure that no have a negative Mantoux prior to contact with residents and that the receive a two step Mantoux. Staff residents will have Mantoux read a state recommendations. 1. Corrective Action: A.)New staff included in the survey audits done with TB test repeated indicated. B.)Resident chart reviewed. No sig symptoms of TB. Mantoux (one st be repeated. (08/06/15). C.) Policy and Procedure reviewed nursing staff.	ew staff direect ey and as per y had file as need gns and ep) will	

Minnesota Department of Health

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S	
		00288	B. WING		07/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HERITAC	SE LIVING CENTER		SIXTH STR			
III III I		PARK RAI	PIDS, MN 5	6470	Ţ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21426	Continued From pa		21426			
	step TST test result LPN-D's date of hire TST was performed screening for symping re-administer the TSO days prior to LPI residents. NA-A's date of hire TST was administed started with direct reprior to having a TSO second step TST worder was administed have a second TSTO A-A's date of hire TST was administed have a second TSTO A-A's date of hire worder was there documentation the was the was administed to have a second TST when the was the was administed to have a second TST was	t was not read. e was 7/1/15. The first step d on 1/31/15. LPN-D had no toms, nor did the facility ST due to it being given over N-D's direct contact with was 3/5/15. NA-A first step red on 3/12/15, although NA-A esident contact on 3/6/15, ST. NA-A had no date when a as completed. was 3/5/15. KA-A first step red on 3/9/15. KA-A did not administered. as 5/27/15. A-A's first step red on 5/27/15. A-A had no first step TST was read, nor atation a second step TST was TST was administered on R59's medical records lacked ults for the second TST. on 7/22/15, at 1:04 p.m., DON) stated When orientation, they get their first y begin to work with residents. e given notices when they are but stated, "That doesn't do it." DON stated results are N staff, but it may not always it should be. Tuberculosis Prevention and indicated the facility must prior to employment and volunteering, show freedom I all employees and volunteers		2. Corrective Action as it pertains to others: A.) QA audit will done on all new employees for one year. B.) Results will be reviewed by QA Committee quarterly for one year tensure on going compliance. 3. Re-occurrance will be prevented A.) QA audits and staff reminders on going basis. B.) Will cover the need to have Maread and two step completed in a manner. 4. POC will be monitored by: DON Supervisor, Department Heads, Administrator. 5. Correction date: 08/31/15.	d by: on an asntoux timely	
	addition, the policy	tested prior to employment. In indicated written luding the dates and results)				

Minnesota Department of Health

STATE FORM 5ENO11 If continuation sheet 23 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00288	B. WING		07/2	3/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HERITAGE LIVING CENTER 619 WEST PARK RAP							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ge 23	21426				
		esting and evaluation will be the resident's medical record.					
	The administrator of assessment process to be sure the docu	HOD OF CORRECTION: or designee could review the set for employees and residents mentation of the TST are ministrator or designee could nce.					
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty one					
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			8/31/15	
	Drugs used in the n in accordance with	oursing home must be labeled part 6800.6300.					
	by: Based on observati review the facility fa secure disposal of a analgesic medicatic currently accepted a diversion for 5 of 5 R32) reviewed with In addition, the facil pharmacy labeling of	on, interview, and document alled to ensure safe and used Fentanyl (topical narcotic on) patches according to principles to prevent potential residents (R59, R31, R8, R12, prescribed Fentanyl patches ity failed to ensure accurate was completed for 2 of 4 29) in the facility who receive		See POC for F 431 Correction Date: 08/31/15.			
	Findings include:						
	Fentanyl Patch eve microgram/hour (m	ler dated 7/16/15, indicated ry 72 hours, apply 12 cg/hr) transdermally, every 3 day(s) for pain. Remove old					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION (X3) DATE S		
		00288	B. WING		07/2	3/2015
				STATE, ZIP CODE		
HERITAG	SE LIVING CENTER		SIXTH STR PIDS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 24	21620			
ı	patch prior to apply	ing new patch.				
	R31's physician order dated 7/22/15, indicated Fentanyl Patch every 72 hours apply 24 mcg transdermally, every 72 hours for compression fracture.					
	R8's physician order dated 3/5/15, indicated Fentanyl Citrate Film apply 50 mcg/hr transdermally, one time a day, every 3 days, related to chronic pain syndrome.					
	R12's physician order dated 6/15/15, indicated Fentanyl Patch every 72 hours apply 25 mcg/hr, transdermally every 72 hours for pain.					
	R32's physician order dated 7/9/15, indicated Fentanyl Citrate film, apply 12 mcg transdermally one time a day, every 2 days for pain.					
	licensed practical n placing a new Fenta old patch is first ren patch is placed. LP up into small pieces sharps container or LPN-E stated the na signs in the electron record (eMAR) for t patch and destruction	7/23/15, at 10:18 a.m. urse (LPN)-E stated when anyl patch on a resident, the noved and the new dated PN-E stated the old patch is cut and disposed of in the at the side of the med cart. urse administering the patch nic medication administration he administration of the new on of the old patch. LPN-E is not witnessed or signed off				
	LPN-B stated the us and put into the sha nurse witnessed the	on 7/23/15, at 10:53 a.m. sed Fentanyl patch is cut up arps container, and a second e destruction, however, she here the second nurse would as completed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00288	B. WING		07/2	3/2015	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HERITAC	GE LIVING CENTER		T SIXTH STR PIDS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21620	Continued From pa	ge 25	21620				
	LPN-C stated when patch it is witnessed LPN-C was unsure would document this when interviewed of director of nursing (Fentanyl patch should and disposed of interequired to be witned DON stated the factive verify a second nursidestruction of the Figure 1.	on 7/23/15, at 11:45 a.m. (DON) stated the used uld be cut into small pieces the sharps container, which is essed by a second nurse. The ility had no documentation to					
	12/31/14, indicated from a resident the patch via the Black in the presence of a cut up prior to place both signatures will medical record. During observation LPN-E the North ba one open Lantus (ir control diabetes) pr the facility medical on it (name, date of label. There was nopened, or when it	tled Duragesic Patches dated when a patch is removed staff is to dispose of the old Hazardous Waste Container a witness. The patch will be ement in waste container, and be recorded in the resident's on 7/23/15, at 10:18 a.m. with ack medication cart included insulin medication used to refilled pen with a label from chart with R54's information of birth), but had no pharmacy of date on the pen when it was would expire. LPN-E stated on may have come with R54					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00288	B. WING		07/2	23/2015	
	PROVIDER OR SUPPLIER	619 WES	DDRESS, CITY, STATE, ZIP CODE ST SIXTH STREET APIDS, MN 56470				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21620	On 7/23/15, at 10:2 north medication ro Lantus prefilled per in an opened box. R54's medical char but no pharmacy la On 7/23/15, at 10:4 insulin pen was rec would use a resider On 7/23/15, at 10:5 north front cart with (insulin medication for R8 with a pharm being opened, no dwas opened, or who During interview on stated insulin shoul DON also stated insulin shoul DON also stated insulin from the hospital st a label from the fac opened on the pen/ The facility policy tit dated 6/2011, did no vials. SUGGESTED MET The Director of nurs policies and proced are dated when ope standards of practic of medication. The educate nursing state could monitor staff	9 a.m. observation of the om with LPN-E included one in unopened, in the refrigerator. The pen had a label from the with R54's information on it, bel. 4 a.m. LPN-C stated if an eived with no label on it, she introduced it with read it and eived with no label on it, she introduced it is a not label from the facility chart. 3 a.m. observation of the LPN-B included a Novolog used to control diabetes) vial in acy label on. Despite the vial ate was noted as to when it is en it would expire. 7/23/15, at 11:04 a.m. DON do be dated when opened. Solin that comes with residents aff had been instructed to use illity chart and put the date invial. Ited Multi Dose Vials revision of address insulin pens or insulin pens	21620				
	(21) days	TOOTHLOTION. TWEITLY OHE					

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PRINTED: 08/20/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _ 00288 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **619 WEST SIXTH STREET HERITAGE LIVING CENTER** PARK RAPIDS, MN 56470 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)