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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5ENO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00288

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245405**

2.STATE VENDOR OR MEDICAID NO.
(L2) **924240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE LIVING CENTER**
(L4) **619 WEST SIXTH STREET**
(L5) **PARK RAPIDS, MN** (L6) **56470**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/14/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/24/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/27/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245405	A. Building B. Wing	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
HERITAGE 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
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/31/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/31/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/31/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/31/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/31/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/31/2015**
ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **08/31/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	09/24/2015	29249	09/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/23/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245405	A. Building B. Wing **02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS**	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
HERITAGE 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
ID Prefix	Correction Completed **08/31/2015**	ID Prefix	Correction Completed **08/31/2015**	ID Prefix	Correction Completed **07/23/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0046		LSC K0050	
ID Prefix	Correction Completed **07/23/2015**	ID Prefix	Correction Completed **08/31/2015**	ID Prefix	Correction Completed **07/23/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0054		LSC K0056		LSC K0062	
ID Prefix	Correction Completed **08/31/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0067		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KJ	09/24/2015	27200	09/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/22/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5ENO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00288

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245405**

2.STATE VENDOR OR MEDICAID NO.
(L2) **924240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HERITAGE LIVING CENTER**
(L4) **619 WEST SIXTH STREET**
(L5) **PARK RAPIDS, MN** (L6) **56470**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/23/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Christi Bodick-Nord, HFE NEII — 08/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/27/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide services in accordance with the plan of care for 1 of 1 residents, (R54) reviewed for dialysis. Findings include: R54 was admitted to the facility on 7/2/15. R54's admission Minimum Data set (MDS) dated 7/8/15, noted R54 was cognitively intact, had diagnosis including end stage renal disease (ESRD), diabetes mellitus, anemia, and	F 282	It is the policy of Heritage Living Center to follow each resident's plan of care. 1. Corrective Action: A.) R54 care plan was reviewed. On 07/24/15 short dialysis care plan with quick access for all staff added to R54 communication file. B.)On 07/31/2015 making sure blood pressure taken in correct arm was added to CNA Kardex to alert them. C.) On 08/04/2015 education posted on wing for the following areas: daily weights, blood pressure procedures, left upper arm	8/31/15

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

Electronically Signed | 08/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 hypertention, and received dialysis treatment at an outside facility. R54's DaVita's dialysis care plan (undated) instructed staff: -Daily weights should be obtained using the same scale, amount of clothing and approximately the same time with each weight. -Blood pressure should never be taken on an extremity that contains a dialysis access or may be used for future access. -It also noted R54 had a left upper arm fistula (direct connection of an artery to a vein, used to administer dialysis treatment), and staff was to check the extremity access daily, which included feeling for a pulsation in the assess, listening for a bruit via stethoscope in the access, and assessing for redness, warmth or signs of infection. -Access dressings and bandages may be removed within 6-8 hours following dialysis. R54's facility initial (short term) care plan dated 7/2/15, indicated the resident was at risk for complications related to diabetes mellitus type 2, and receiving hemodialysis Monday, Wednesday, and Friday. Under the dialysis section, the care plan indicated R54 had end stage renal disease stage 4, and interventions included no blood pressure in arm with graft (although the resident had a fistula, and the care plan did not direct staff where the access was located), monitor/document/report as needed any signs/symptoms of infection to access site including redness, swelling, warmth, or drainage, Monitor/document/report as needed signs/symptoms of bleeding, hemorrhage, bacterium, and septic shock, check paperwork upon return from dialysis, and chart dialysis	F 282	fistula check daily, (feeling for pulsation,listening for a bruit via stethoscope, and assessing area for redness, warmth or signs of infection), and to remove the access dressings/bandages within six to eight hours after dialysis. D.) Education provided 08/04/15 on charting on return any signs/symptoms of bleeding, hemorrhage, bacterium, and septic shock. E.)Also included in the education on 08/04/2015: On return from dialysis nurse (LPN/RN)is to check paperwork from the dialysis unit and chart dialysis weight in Point Click Care, obtain full set of vitals, check for bruit/thrills, and monitor for signs of bleeding at the site. F.) Instructions were added to treatment sheet on 08/04/15 by MDS Coordinator. 2. Corrective Action as it relates to other residents: A.) Short care plan added to communication book for quick staff reference. B.) Education provided to staff for all residents on dialysis with emphasis on individual needs for each resident. (08/06/15 new manuals reviewed with staff.) C.) Instructions added to treatment sheet for each resident on dialysis. D.) Policy and Procedure for dialysis written and shared with staff 08/05/15-08/20/15. 3. Re-occurrence will be prevented by: A.) QA audit will be done weekly for 30 days and then monthly for 60 days to ensure the plan of care is being followed.	

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F 282	Continued From page 2 weight in Point Click Care (computerized patient record), obtain full set of vital signs, check for bruit/thrills, and monitor for signs of bleeding at sight. During interview on 7/22/15, at 8:43 a.m. licensed practical nurse (LPN)-A stated she does check R54's access site once per shift, however, she stated she did not document this in the medical record. LPN-A stated dialysis patients get weighed three times per week, however, LPN-A looked in R54's medical record and verified there was only two weights completed for R54 since admission on 7/2/15. During interview on 7/22/15, at 8:52 a.m. R54 stated staff do not look at her access site on her return from dialysis. R54 stated her fistula is covered by gauze and tape when leaving dialysis, and she removes it herself after she returns to the facility. R54 stated staff at the facility have never listened or felt her fistula. When interviewed on 7/22/15, at 8:59 a.m. nursing assistant (NA)-E stated there was nothing special related to obtaining a blood pressure on R54, and there was nothing special related to the residents dialysis treatments she should be aware of. When interviewed on 7/23/15, at 10:07 a.m. LPN-E stated when R54 returns from dialysis she would just ask how she is doing, and weights are completed monthly unless ordered otherwise. LPN-E verified there is no documentation to ensure R54's access site is being monitored. Review of R54's medication administration record, and treatment administration record, for	F 282	B.) QA results will be taken to QA committee to see if further action is required. 4. The POC will be monitored by Unit Manager, MDS Coordinator and DON. 5. Correction Date: 08/31/2015	

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F 282	Continued From page 3 July 2015, failed to identify an order for special weights or treatment related to pre or post dialysis care or assessment. Review of facility progress notes from R54's record from 7/2/15 - 7/23/15, indicated 7/6/15, 7/8/15, 7/13/15 pre and post dialysis weights were noted, however, there were no other weights from the remaining days of dialysis. The facility policy titled Care Planning Team review dated 5/11, indicated the purpose of the care plan is to assure continuity of care at admission, to assure residents' needs can be bet at admission, and to provide a system for ongoing process of developing and updating a comprehensive care plan with input form the resident, family, representative, and an interdisciplinary team. It also noted areas of vulnerability are included in the initial care plan, and the comprehensive care plan is used by all personnel involved in the care of the resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate dialysis services for 1	F 309	It is the policy of Heritage Living Center to provide the necessary care and services	8/31/15

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F 309	Continued From page 4 of 1 residents (R54) reviewed for dialysis. Findings include: R54 was admitted to the facility on 7/2/15. R54's admission Minimum Data set (MDS) dated 7/8/15, noted R54 was cognitively intact, had diagnosis including end stage renal disease (ESRD), diabetes mellitus, anemia, and hypertention, and received dialysis treatment at an outside facility. R54's DaVita's dialysis care plan (undated) instructed staff: -Daily weights should be obtained using the same scale, amount of clothing and approximately the same time with each weight. -Blood pressure should never be taken on an extremity that contains a dialysis access or may be used for future access. -It also noted R54 had a left upper arm fistula (direct connection of an artery to a vein, used to administer dialysis treatment), and staff was to check the extremity access daily, which included feeling for a pulsation in the assess, listening for a bruit via stethoscope in the access, and assessing for redness, warmth or signs of infection. -Access dressings and bandages may be removed within 6-8 hours following dialysis. R54's facility initial (short term) care plan dated 7/2/15, indicated the resident was at risk for complications related to diabetes mellitus type 2, and receiving hemodialysis Monday, Wednesday, and Friday. Under the dialysis section, the care plan indicated R54 had end stage renal disease stage 4, and interventions included no blood	F 309	to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. Corrective Action: A.) See under F-282 also. B.) Care Plan reviewed and a short dialysis care plan put in communication book 07/29/15 for easy access to staff. C.) On 08/04/15 education was provided to staff related to dialysis instructions. D.) On 08/04/15 treatment sheet was updated to include needed plan of care items. E.) Weekly QA will be done for 30 days and then QA will be done monthly for 60 days to ensure compliance. 2. Corrective Action as it relates to other residents: A.) See under F-282 also. B.) All residents on dialysis had care plans reviewed. Short care plan added to their dialysis communication book 07/29/15. C.) Treatment sheets update 08/04/15 to include all needed dialysis actions. D.) Education provided to staff 08/05/15. E.) QA monitoring will be done weekly for 30 days and then monthly for 60 days to ensure compliance. 3. Re-occurrence will be prevented by: A.) QA audits will be done as stated above. B.) QA results will be taken to QA committee to determine if further action is needed. C.) Education books will be available on each floor for easy access to information as staff needs. This will be completed by	

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F 309	Continued From page 5 pressure in arm with graft (although the resident had a fistula, and the care plan did not direct staff where the access was located), monitor/document/report as needed any signs/symptoms of infection to access site including redness, swelling, warmth, or drainage, Monitor/document/report as needed signs/symptoms of bleeding, hemorrhage, bacterium, and septic shock, check paperwork upon return from dialysis, and chart dialysis weight in Point Click Care (computerized patient record), obtain full set of vital signs, check for bruit/thrills, and monitor for signs of bleeding at sight. During interview on 7/22/15, at 8:43 a.m. licensed practical nurse (LPN)-A stated she does check R54's access site once per shift, however, she stated she did not document this in the medical record. LPN-A stated dialysis patients get weighed three times per week, however, LPN-A looked in R54's medical record and verified there was only two weights completed for R54 since admission on 7/2/15. During interview on 7/22/15, at 8:52 a.m. R54 stated staff do not look at her access site on her return from dialysis. R54 stated her fistula is covered by gauze and tape when leaving dialysis, and she removes it herself after she returns to the facility. R54 stated staff at the facility have never listened or felt her fistula. When interviewed on 7/22/15, at 8:59 a.m. nursing assistant (NA)-E stated there was nothing special related to obtaining a blood pressure on R54, and there was nothing special related to the residents dialysis treatments she should be aware of.	F 309	08/06/15. 4. The POC will be monitored by: Unit MAnager, MDS RN, and DON 5. Date of Completion: 08/31/2015.	

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F 309	Continued From page 6 When interviewed on 7/23/15, at 10:07 a.m. LPN-E stated when R54 returns from dialysis she would just ask how she is doing, and weights are completed monthly unless ordered otherwise. LPN-E verified there is no documentation to ensure R54's access site is being monitored. When interviewed on 7/23/15, at 2:21 p.m. registered nurse (RN)-B stated R54 had some, "Missing information" in her medical chart related to the special cares staff needed to provide for a dialysis patient. RN-B verified staff should be obtaining the residents weight and vital signs daily, and there should be an order and direction to staff to check the access site when R54 returns from dialysis treatment. When interviewed on 7/23/15, at 8:51 a.m. NA-D stated there was nothing special staff needed to know regarding obtaining a blood pressure on R54. NA-D went to check R54's care plan, and stated there was no mention about precautions on taking R54's blood pressure. R54's physician orders from 7/2/15 - 7/23/15, indicated no orders for weights other than monthly per protocol. Review of R54's medication administration record, and treatment administration record, for July 2015, failed to identify an order for special weights or treatment related to pre or post dialysis care or assessment. Review of facility progress notes from R54's record from 7/2/15 - 7/23/15, indicated 7/6/15, 7/8/15, 7/13/15 pre and post dialysis weights were noted, however, there were no other	F 309		

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F 309	Continued From page 7 weights from the remaining days of dialysis. Facility policy related to dialysis was requested but none provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance with nail care and removal of facial hair for 1 of 2 residents (R14) who were dependent upon staff to maintain grooming. Findings include: R14's diagnosis as noted on the admission record dated 4/14/08, included senile dementia, macular degeneration of the retina, and osteoporosis. R14's quarterly Minimum Data Set (MDS), dated 7/5/15, indicated R14 was rarely/never understood, had long and short term memory problems, required extensive assistance of one staff for transferring, locomotion on and off the unit, dressing, toileting, personal hygiene and bathing, and supervision for eating. R14's plan of care, dated 7/10/15, directed staff	F 312	It is the policy of HLC to provide the necessary services to maintain good nutrition, grooming, and personal and oral hygeine. 1. Corrective Action: A.) On 7/23/15 resident allowed staff to complete cares. Nail care, hair care and shaving were completed. B.) DON doing (three times a week for two weeks) QA to ensure resident continued to receive grooming needs. C.) On 07/27/15 staff involved with residents care was re-educated on need to report to charge nurse or Unit Manager if a resident refused care. D.) Education also provided on ways to approach resident if she was combative with cares. E.) Weekly QA checks will be done for three months starting 08/01/15 by charge nurse/UM/DON. 2. Corrective Action as it pertaind to other	8/31/15

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F 312	Continued From page 8 to give clear explanation of all care activities prior to and during each contact, and if R14 resists assistance with activities of daily living (ADL), staff were to reassure R14, leave, and return 5-10 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 lip and under the chin. During observation on 7/22/15, at 2:29 p.m., R14 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 long, jagged, and dirty, and the facial hair remained on 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 and their nails were cared for. NA-B stated nail care was usually performed when the residents had a 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 or facial hair shaved, but stated if R14 refused, staff would typically reapproach her and she would	F 312	residents: A.)On 08/04/15 education provided to nursing staff on proper cares and what to do if a resident refuses. B.) A QA audit of random residents will be conducted weekly for one month and then monthly for three months. C.) Results will be taken to QA committee to determine if further action is needed. D.) Nursing staff meetings will be held 08/11/15, 08/12/15 and 08/13/15 to review education material. 3. Re-occurrence will be prevented by: A.) QA audits as mentioned above with results taken to IDT and QA Committee for further action. B.) Annual staff education on dealing with residents who refuse cares. Education given 08/04/15. A follow up inservice will be provided Sept. 16th, 2015 by Maria Reyes, Awakening RN. 4. The POC will be monitored by: Charge Nurse, Unit Manager and DON. 5. Correction Date: 08/31/15.	

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F 312	Continued From page 9 allow the cares to be completed at a later time. During an interview on 7/23/15, at 8:50 a.m., NA-C stated she had given R14 a bed bath on 7/22/15, and verified R14's nail care and hair removal were not completed after giving the bath on 7/22/15, although NA-C could not indicate why. During an interview on 7/23/15, at 9:57 a.m., family member (FM)-A indicated the staff did not consistently provide grooming assistance for R14's nail care and facial hair removal, and stated, "I mentioned it a couple of weeks ago again." FM-A stated she had talked to director of nursing (DON) a few months ago and staff got better about ensuring the cares were complete, however, lately she felt the cares were not being completed. FM-A stated R14 used to pull out the facial hair, adding, "[R14] always took care of that herself. I think the facial hair bothered [R14] when she was still aware of her surroundings." During an interview on 7/23/15, at 10:39 a.m., DON stated staff are instructed to go to the registered nurse or to the unit manager if they are having trouble completing cares for a resident. If a resident refuses cares, staff are trained to wait and go back five minutes later to try again, or to have someone else try. A facility policy for providing grooming services for residents dependent on staff was requested but not provided.	F 312		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		8/31/15

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F 371	Continued From page 10 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen refrigerators maintained appropriate temperature controls for the safe storage of food items. The facility also failed to ensure required chemical levels for sanitization were maintained for kitchen equipment cleaned using the facility's three-compartment sink. This had the potential to affect all 46 residents who were routinely served meals from the facility kitchen. Findings include: During the initial kitchen tour on 7/20/15, at 2:18 p.m. the facility's meat cooler was observed with the exterior thermometer blinking and a temperature reading of 43 degrees Fahrenheit (F). However, a thermometer located inside the cooler read 46 degrees F. Cook (C)-A stated he was unsure of why the temperature reading was blinking on the cooler's exterior thermometer. Also during the tour, the facility's kitchen was noted as equipped with both a three-compartment sink with chemical sanitization, and a dish washer for high temperature sanitization. During a follow-up kitchen tour on 7/22/15, at	F 371	It is the policy of Heritage Living Center to store,prepare,and distribute food under sanitary conditions as apporved by Federal, State and local authorities. 1 Corrective Action and 2: Corrective Action as it relates to all residents: A.)Staff to check temps daily on refridgerator and notify CDM or Environmental Service Supervisor if not in proper temperature range. B.) Three compartment sinks will be tested at least daily by dietary staff and monthly by Ecolab service representative. C.) Staff education was provided on appropriate tempratures and what to do if not in acceptable range. Education also provided to dietary staff on testing with chemical strips the three compartment sink. Test strips will be stocked in chemical room. 3. Re-occurrence will be prevented by: A.) QA will be done weekly for 90 days by CDM to monitor compliance with temperature logs and sanitizer checks. B.) QA weekly for 90 days (and on going) to ensure adequate stock of test strips.	

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F 371	Continued From page 11 10:59 a.m. the exterior thermometer of the facility's meat cooler was observed as blinking, with a temperature reading of 37 degrees F. The interior thermometer read 40 degrees F. At 11:10 a.m., after C-B and dietary aide (DA)-A opened and closed the cooler several times during meal preparation, the exterior thermometer continued to blink, with a temperature reading of 42 degrees F. The interior thermometer read 45 degrees F. At 11:24 a.m., nearing the end of meal preparation activities, the exterior thermometer continued to blink, with a temperature reading of 45 degrees F and an interior temperature reading of 48 degrees F. The interior thermometer consistently revealed temperature readings of approximately three degrees F above the exterior thermometer. During interview at this time, C-B stated the exterior thermometer typically flashed on and off repeatedly when there was a power outage, but she did not know why it had been blinking for several weeks now. She stated pressing the reset button on the cooler was supposed to resolve the blinking, but each time she tried to reset it, the blinking returned shortly thereafter. C-B confirmed the facility's certified dietary manager (CDM) was aware of these concerns, and she was responsible for review of all temperature logs for the facility's kitchen coolers and freezers. Also during this follow-up tour, the facility's three-compartment sink was observed filled with various fluids/ solutions, with a dish washing cart holding one plastic cutting board, two Dycem (a manufacturer of non-slip products) mats, and a weaved plastic mat located next to the sink. DA-B stated most dishes and equipment were run through the dish washer for high temperature sanitization, but added that items such as the	F 371	4. The POC will be monitored by: Administrator, Dietary Supervisor, and Environmental Services Supervisor. 5. Correction Date: 08/31/2015.	

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F 371	Continued From page 12 plastic mats were solely cleaned using the three-compartment sink because the high temperature dish washer melted the plastic/ Dycem mats. At that time, several weaved plastic mats were observed being used in the dish drying area, placed atop meal trays, with freshly cleaned cups turned upside-down, with the lips of the cups pressed against the mats while the cups were left to air dry. DA-B stated the chemicals for the three-compartment sink were tested routinely and logged, however, DA-B was unable to locate any of the test strips. At 11:30 a.m., DA-C stated she was typically responsible for testing the three-compartment sink solution for the required chemical levels, however, she had been unable to locate any test strips for testing the chemicals since the beginning of the month. She stated the facility's CDM was aware there were no test strips available and stated she believed the CDM had been having a difficult time getting the chemical sanitization company to send test strips to the facility. Review of REFRIGERATOR FREEZER TEMP SHEETS for the facility's meat cooler from 6/17/15, through 7/22/15, temperatures were outside of acceptable ranges for 22 out of 71 (31%) of temperature recording opportunities, including the following: On 6/17/15, the evening shift logged a temperature of 62 degrees F. On 6/19/15, the day shift logged a temperature of 42 degrees F and the evening shift logged a temperature of 43 degrees F. On 6/20/15, the day shift logged a temperature of 42 degrees F. On 6/22/15, the day shift logged a temperature of 48 degrees F and the evening shift logged a	F 371		

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F 371	Continued From page 13 temperature of 51 degrees F. On 6/23/15, the day shift logged a temperature of 45 degrees F. On 6/27/15, the day shift logged a temperature of 43 degrees F. On 6/28/15, the day shift logged a temperature of 45 degrees F. On 7/2/15, the evening shift logged a temperature of 52 degrees F. On 7/6/15, the day shift logged a temperature of 48 degrees F and the evening shift logged a temperature of 42 degrees F. On 7/7/15, the day shift logged a temperature of 42 degrees F. On 7/8/15, the evening shift logged a temperature of 50 degrees F. On 7/9/15, the evening shift logged a temperature of 42 degrees F. On 7/12/15, the day shift logged a temperature of 42 degrees F and the evening shift logged a temperature of 44 degrees F. On 7/13/15, the evening shift logged a temperature of 42 degrees F. On 7/14/15, the day shift logged a temperature of 48 degrees F. On 7/16/15, the day shift logged a temperature of 42 degrees F. On 7/17/15, the evening shift logged a temperature of 42 degrees F. On 7/18/15, the day shift logged a temperature of 42 degrees F. The logs also lacked readings for an additional 17 of 71 (24%) of opportunities. The temperatures logged did not differentiate whether the interior or exterior thermometer was referenced, however, notations of "flashing" behind most temperatures logged during the day shift, suggested the temperatures were read from the exterior	F 371		

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F 371	Continued From page 14	F 371		

thermometer.

Review of DISHWASHER TEMP SHEET for the facility's three-compartment sink from 7/1/15, through 7/22/15, identified no test strips were available for 30 of 64 (47%) entry opportunities, with entries lacking for an additional 33 of 64 (52%) entry opportunities. The entry of 400 parts-per million (ppm) on 7/13/15, during the supper meal, was the only test strip result recorded during this time period.

During interview on 7/23/15, at 11:29 a.m. the CDM stated staff were to reference the interior thermometer of coolers/ freezers when logging temperature readings, as the exterior thermometers were "not reliable." The CDM stated if a cooler temperature was noted as above 41 degrees F, the staff were to re-check the temperature later in their shift, at a time when the cooler was not being frequently accessed, and if the second temperature reading remained above 41 degrees F, the staff were to report the concern to herself or the facility's maintenance crew. The CDM also stated she reviewed the temperature logs for kitchen coolers about twice weekly, however, she stated she was not aware of any concerns the meat cooler had temperature readings above 41 degrees F. The CDM reported kitchen coolers were to remain at 41 degrees F or below, to ensure safe food storage. CDM stated the following food items were generally stored in the meat cooler: Breakfast meats, bagged/ liquid pasteurized eggs, glasses of juice prepared for upcoming meals, and raw meats thawing for upcoming meals. The CDM acknowledged the facility was low on test strips for a short period of time, but then received some prior to her leaving for vacation the week prior. She was not aware

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F 371	Continued From page 15 C-C had not located test strips for her routine testing of the three-compartment sink. CDM stated the facility's chemical sanitization system was evaluated monthly by Ecolab (the chemical supplier) and she reviewed the DISHWASHER TEMP SHEETS daily. CDM stated C-C typically told her when the kitchen had run out of test strips, but she had not been informed of this to date. The facility's CLEANING OF 3 [three] COMPARTMENT SINKS policy dated 4/1/15, directed chemical sanitizing solutions were to be tested periodically to maintain appropriate levels and to ensure three-compartment sinks were preserved in clean and sanitary condition.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		8/31/15

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F 431	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 Fentanyl Patch every 72 hours apply 24 mcg	F 431	It is the policy of the facility to maintain 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 a paper copy of destruction of Fentanyl since change from KNS to PCC electronic system. This was not completed on a consistent basis. The destruction of the Fentanyl patch has now been entered into PCC and will trigger an alert if the second 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 insulin bottles/ insulin pens and any multi-dose vial. This was done verbally to full and part time nurses as well as in written material to casual and all nurses. C.) The charting in the observation is	

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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, 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. When interviewed on 7/23/14, at 10:44 a.m. LPN-C stated when destroying an old Fentanyl	F 431	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. 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 were reviewed and medication sheet updated in PCC. B.) Medication carts and refridges were checked to make sure there were no other medications out of compliance. 3. Re-occurrence will be prevented by: A.) Weekly QA for one month and then monthly QA for three months. B.) Pharmacy check monthly on an on going basis. C.) All QA results will be taken to QA committee for review and recommendations for further monitoring. 4. The POC will be monitored by: Charge nurses,Unit MAnagers, DON, Pharmacists. 5. Correction Date: 08/31/15.	

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patch it is witnessed by two nurses, however, LPN-C was unsure where the second nurse would document this was completed.

When interviewed on 7/23/15, at 11:45 a.m. director of nursing (DON) stated the used Fentanyl patch should be cut into small pieces and disposed of in the sharps container, which is required to be witnessed by a second nurse. The DON stated the facility had no documentation to verify a second nurse is witnessing the destruction of the Fentanyl patch due to a computer system issue, however, she stated the corporate office was currently working on a solution.

The facility policy titled Duragesic Patches dated 12/31/14, indicated when a patch is removed from a resident the staff is to dispose of the old patch via the Black Hazardous Waste Container in the presence of a witness. The patch will be cut up prior to placement in waste container, and both signatures will be recorded in the resident's medical record.

During observation on 7/23/15, at 10:18 a.m. with LPN-E the North back medication cart included one open Lantus (insulin medication used to control diabetes) prefilled pen with a label from the facility medical chart with R54's information on it (name, date of birth), but had no pharmacy label. There was no date on the pen when it was opened, or when it would expire. LPN-E stated she believed the pen may have come with R54 from the hospital.

On 7/23/15, at 10:29 a.m. observation of the north medication room with LPN-E included one

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F 431	Continued From page 19 Lantus prefilled pen, unopened, in the refrigerator in an opened box. The pen had a label from R54's medical chart with R54's information on it, but no pharmacy label. On 7/23/15, at 10:44 a.m. LPN-C stated if an insulin pen was received with no label on it, she would use a resident label from the facility chart. On 7/23/15, at 10:53 a.m. observation of the north front cart with LPN-B included a Novolog (insulin medication used to control diabetes) vial for R8 with a pharmacy label on. Despite the vial being opened, no date was noted as to when it was opened, or when it would expire. During interview on 7/23/15, at 11:04 a.m. DON stated insulin should be dated when opened. DON also stated insulin that comes with residents from the hospital staff had been instructed to use a label from the facility chart and put the date opened on the pen/ vial. The facility policy titled Multi Dose Vials revision dated 6/2011, did not address insulin pens or vials.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		8/31/15

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F 441	Continued From page 20 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi use glucometer (device utilized for monitoring blood sugars) was appropriately disinfected between resident use for 2 of 2 residents (R74 & R29) observed to utilize the community glucometer from the North Back medication cart. Findings include:	F 441	Heritage Living Center has an established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Corrective Action and 2. Corrective Action as it applies to other residents:	

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F 441	Continued From page 21 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 completely wiped and remain wet for 2 minutes between patient use to ensure appropriate disinfection. When interviewed on 7/22/15, at 12:00 p.m.	F 441	A.) Nurse (LPN)A was counseled on improper cleaning and not following the policy and procedure for cleaning the glucometer. She had training in Nov. 2014 and training was repeated 07/23/15 on the correct procedure. B.) Nurse (LPN)C had also had training 11/14 and was also given repeat education on 07/23/15 on the correct procedure. C.) On 07/27/15 each nurse was given a copy of the policy and procedure. Nurses meeting will be held 08/12/15 to reinforce the policy. D.) A step by step poster with proper cleaning was put on each medication cart top as a reminder. E.)On 07/27/15 Policy and Procedure was re-written in an easier to follow format and replaced in P&P manuals. 3. Re-occurrence will be prevented by: A.) QA audit will be done weely for one month by randomly asking staff the procedure and then monthly for three 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.	

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F 441	Continued From page 22 LPN-C stated the community glucometer is to be wiped off with the SuperSaniCloth, however, she was not aware if there was a certain amount of time the glucometer was to remain wet before being used again. When interviewed on 7/22/15, at 12:14 p.m. director of nursing (DON) stated the glucometers are to be cleaned between each use with the purple topped SuperSaniCloth wipes, and the glucometer should remain wet for 2 minutes to ensure disinfection 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.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain the kitchen refrigerator equipment in good repair. This had the potential to affect all 46 residents who were	F 456	It is the policy of Heritage Living Center to maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.	8/31/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 23 routinely served meals from the facility kitchen. Findings include: During the initial kitchen tour on 7/20/15, at 2:18 p.m. the facility's meat cooler was observed with the exterior thermometer blinking and a temperature reading of 43 degrees Fahrenheit (F). However, a thermometer located inside the cooler read 46 degrees F. Two medium-sized, metal steam tray containers were observed on top of a plastic meal tray on the top shelf of the cooler, just below the cooler's condensing unit. Both containers were noted with approximately one-half, to one inch of water inside. Cook (C)-A was asked about the purpose of the steam tray pans with water inside, and he stated the containers were placed beneath the condensing unit to capture condensation dripping from the ceiling of the fridge. C-A stated he was unsure of why the temperature reading was blinking on the cooler's exterior thermometer, and stated he was unsure of the kitchens process to fix equipment. C-A stated the facility's certified dietary manager (CDM) was aware condensation had been dripping beneath the condensing unit of the meat cooler, however, nothing had been done to complete any repairs of the cooler. During a follow-up kitchen tour on 7/22/15, at 10:59 a.m. the exterior thermometer of the facility's meat cooler was observed as blinking with a temperature reading of 37 degrees F. The interior thermometer read 40 degrees F. At 11:10 a.m., after C-B and dietary aide (DA)-A opened and closed the cooler several times during meal preparation, the exterior thermometer continued to blink, with a temperature reading of 42 degrees F. The interior thermometer read 45 degrees F.	F 456	1. Corrective Action and 2. Corrective Action as it relates to all residents: A.) Filters changed, an outside company added free-on to the fridge on 07/23/15. Refridge is working with proper temperatures now. 3. Re-occurrence will be prevented by: A.) Added to TEIS program so maintenance will check coolers bi-monthly. B.) If temps are not within proper range dietary staff will notify maintenance so it can be fixed. C.)Staff to do QA on temps and notify CDM/Maintenance. Staff have been educated on proper temps and notification protocol. 4. The POC will be monitored by: Administrator, Dietary Supervisor, Environmental Services Suervisor. 5. Correction Date: 08/31/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING _____ B. WING _____	07/23/2015

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HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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F 456	Continued From page 24	F 456		

The two metal steam tray containers remained atop a pink, plastic meal tray on the top shelf of the cooler. The meal tray was noted with a shallow coating of water. The metal containers were observed with greater than two inches of water resting inside. At 11:24 a.m., nearing the end of meal preparation activities, the exterior thermometer continued to blink, with a temperature reading of 45 degrees F and an interior temperature reading of 48 degrees F. The interior thermometer consistently revealed temperature readings of approximately three degrees F above the exterior thermometer.

During interview on 7/22/15, at 11:24 a.m. C-B stated the facility's maintenance workers were aware of problems with the meat cooler. C-B stated the exterior thermometer typically flashed on and off repeatedly when there was a power outage, but she did not know why it had been blinking for several weeks now. She stated that pressing the reset button on the cooler was supposed to resolve the blinking, but each time she tried to reset it, the blinking returned shortly thereafter. C-B stated the facility maintenance had replaced a filter in the cooler/ condensing unit approximately two weeks prior, however, the dripping/ condensation continued, along with the blinking thermometer. C-B stated all staff was responsible for completing a maintenance request slip for any kitchen equipment in need of repair. C-B confirmed the facility's CDM was aware of these concerns.

Review of REFRIGERATOR FREEZER TEMP SHEETS for the facility's meat cooler identified from 6/17/15, through 7/22/15, temperatures were outside of acceptable ranges for 22 out of 71 (31%) of temperature recording opportunities.

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F 456	Continued From page 25	F 456		

Logged temperatures which were outside of acceptable ranges for safe food storage ranged from 42 degrees F, to 62 degrees F.

During interview on 7/23/15, at 11:29 a.m. the CDM stated if a cooler temperature was noted as above 41 degrees F, the staff were to re-check the temperature later in their shift, at a time when the cooler was not being frequently accessed. If the second temperature reading remained above 41 degrees F, the staff were to report the concern to herself or the facility's maintenance crew. The CDM stated she reviewed the temperature logs for kitchen coolers about twice weekly, however, she stated she was not aware of the concerns the meat cooler had temperature readings above 41 degrees F. The CDM also stated she was not aware of concerns of dripping condensation from the condensing unit in the meat cooler. CDM stated she was aware the dripping of condensation from the ceilings of the kitchen coolers had been a more common occurrence as the coolers had aged, but she was not aware of the current concerns. The CDM was unsure whether facility maintenance was aware of the current condensation concerns in the meat cooler. The CDM reported kitchen coolers were to remain at 41 degrees F or below, to ensure safe food storage.

During interview on 7/23/15, at approximately 2:45 p.m. the facility's director of maintenance stated he contacted a refrigeration repair company on 7/22/15, to address the above noted concerns with the facility's meat cooler. The company had arrived to repair the cooler on 7/23/15, and indicated the meat cooler had been low on Freon (a gas or liquid used as a refrigerant).

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F 456	Continued From page 26 A facility policy addressing maintenance of kitchen equipment was requested, but was not provided.	F 456		

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HERITAGE LIVING CENTER	**619 WEST SIXTH STREET** **PARK RAPIDS, MN 56470**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal division. At the time of this survey Heritage Living Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

EPOC

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145

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.

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	245405	A. BUILDING **02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS** B. WING _____	**07/22/2015**

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building: The Heritage Living Center is a 1-story building with a basement under the 1960 building. The 1960 building was determined to be of Type II(111) construction, is separated form the new assisted living building with a 2-hour fire barrier and has a basement. In 1969 an addition was constructed to the north of the 1960 building, was determined to be of Type II(111) construction and is separated form the 1960 building with 2-hour fire barriers. In 1990 the chapel addition was constructed to the south of the of the 1960 building, was determined to be of Type V(111) construction and is separated from the 1960 building with a 2-hour fire barrier. In 1994 the laundry addition was added to the north of the 1960 building, was determined to be of Type II(111) construction and is separated from the 1960 building and the new assisted living building	K 000		

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	245405	A. BUILDING **02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS** B. WING _____	**07/22/2015**

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K 000	Continued From page 2 with 2-hour fire barriers. In 2000 a main entrance addition was added to the chapel addition to connect the nursing home with the new apartment building to the south west, was determined to be of Type V (111) construction and is separated form the apartment building with a 2-hour fire barrier. The building is divided into 5 smoke zones with 30 minute and 90 minute fire barriers. The entire building and additions are sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with sleeping room smoke detection, detection in common areas and at smoke barrier doors that are held open, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029		8/31/15

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K 029	Continued From page 3 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, observation revealed, that the following conditions were found affecting hazardous storage areas located within the facility: 1. There is a penetration around the sprinkler pipe that is located in storage room N37, and 2. The doors to storage rooms N37 and 107 did not fully close and positively latch into the door frames. This deficient practices was confirmed by the Maintenance Supervisor.	K 029	1. Corrective Action: A.) Environmental Service Supervisor chaulked the two holes that were found and fixed the door. 2. Re-occurrence will be prevented by: A.) QA audit will be done weekly for 30 days and then monthly for 60 days to ensure doors are in good condition. 3. The POC will be monitored by: Adminstrator and Environmental Service Supervisor. 4. Correction Date: 08/31/15.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is	K 046		8/31/15

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K 046	Continued From page 4 provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility failed to conduct the required Monthly 30 second and annual 90 minute testing of the battery backup emergency lights. This deficient practices was confirmed by the Maintenance Supervisor.	K 046	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 will test emergency lighting monthly for 30 seconds and annually for 90 minutes. 3. The POC will be monitored by: Administrator and Environemntal Services Supervisor 4. Correction Date: 08/31/15.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		7/23/15

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K 050	Continued From page 5 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, during the review of all available maintenance documentation and interview with the Maintenance Supervisor it was revealed that the facility failed to conduct any fire drills in the third calendar quarter within the last 12 months. This deficient practices was confirmed by the Maintenance Supervisor.	K 050	1. Corrective Action: A.)Facility did have documentation that was found on 07/23/2015 showing dates/times of fire drills. Information was unavilable to fire marshal at time of inspection. B.) Facility will continue to conduct fire drills in accordance with NFPA Life Safety Code.Dietary Supervisor (Safety Committe) and Environmental Service Supervisor will both keep files with fire drills dates/times. 2. Re-occurrence will be prevented by: A.) QA will be done monthly by Environmental Service Supervisor and / or Safety Committee to ensure fire drills are completed. 3. The POC will be monitored by: Administrator, Dietary Supervisor (Safety Committee) and Environmental Services Supervisor. 4. Correction Date: 07/23/15.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the	K 054	1. Corrective Action:	7/23/15

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K 054	Continued From page 6 available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient practices was confirmed by the Maintenance Supervisor.	K 054	The facility did find paper work on 07/23/15 that the 2014 sensitivity testing of the smoke detectors was completed. The paper work was not readily available when fire marshal was here for inspection. 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 testing and paper work will be kept by ESS. 3. The POC will be monitored by: Administrator and Environmental Services Supervisor. 4. Corrective Date: 07/23/15.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		8/31/15

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K 056	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, observations have revealed that the gauges that are located on the fire sprinkler system have not been recalibrated or replaced within the last 5 years, the last service for the gauges was completed in 2008. This deficient practices was confirmed by the Maintenance Supervisor.	K 056	1. Corrective Action: A.)Gauges that are located on the fire sprinkler system will be recalibrated and replaced by outside company. 2. Re-occurrence will be prevented by: A.) QA will be done by Environmental Service Supervisor to ensure the sprinkler system is maintained in accordance with 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.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00),	K 062	1. Corrective Action: A.) The 2014 report was not in file when Fire Marshal was here for inspection. Paper work found 07/23/15 and is now in	7/23/15

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HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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K 062	Continued From page 8 Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, a review of documentation and interview with the Maintenance Supervisor revealed the facility failed to conduct 1 of 4 quarterly fire sprinkler flow tests and the annual fire sprinkler test that are required by NFPA 13(99) and NFPA 25(98). This deficient practices was confirmed by the Maintenance Supervisor.	K 062	file. An outside company, NOVA, conducts the tests. The tests had been completed as required. 2. Re-occurrence will be prevented by: A.) NOVA will continue to do fire sprinkler flow tests and annual fire sprinkler test that are required by NFPA standards. B.) Environmental Supervisor will do QAs to ensure the test is completed and will keep all paper work in file together. 3. The POC will be monitored by: Administrator and Environmental Service Supervisor 4. Correction Date: 07/23/15.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could	K 067	1. Corrective Action: A.) Environmental Services Department did testing/inspection of the fire and smoke dampers on 07/29/15.	8/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245405	A. BUILDING **02 - 1960 BUILDING & 69, 90, 94, 2000 ADDITIONS** B. WING _____	**07/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE LIVING CENTER	**619 WEST SIXTH STREET** **PARK RAPIDS, MN 56470**

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K 067	Continued From page 9 allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 3:00 PM to 6:00 PM on 07/22/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient practices was confirmed by the Maintenance Supervisor.	K 067	2. Re-occurrence will be prevented by: A.) QA will be done by ESS and added to TELS program to remind staff to complete the task. B.) Proper paper work will be kept to keep record current. 3. The POC will be monitored by: Administrator and the Environmental Service Supervisor. 4. Correction Date: 08/31/15.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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 Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00288	A. BUILDING: _____ B. WING _____	07/23/2015

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HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/20, 7/21, 7/22, 7/23, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to coordinate dialysis services for 1 of 1 residents (R54) reviewed for dialysis. Findings include: R54 was admitted to the facility on 7/2/15. R54's admission Minimum Data set (MDS) dated 7/8/15, noted R54 was cognitively intact, had diagnosis including end stage renal disease (ESRD), diabetes mellitus, anemia, and hypertention, and received dialysis treatment at an outside facility.	2 830	See POC under F282 and F309. Correction Date: 08/31/15.	8/31/15

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2 830	Continued From page 3 R54's DaVita's dialysis care plan (undated) instructed staff: -Daily weights should be obtained using the same scale, amount of clothing and approximately the same time with each weight. -Blood pressure should never be taken on an extremity that contains a dialysis access or may be used for future access. -It also noted R54 had a left upper arm fistula (direct connection of an artery to a vein, used to administer dialysis treatment), and staff was to check the extremity access daily, which included feeling for a pulsation in the assess, listening for a bruit via stethoscope in the access, and assessing for redness, warmth or signs of infection. -Access dressings and bandages may be removed within 6-8 hours following dialysis. R54's facility initial (short term) care plan dated 7/2/15, indicated the resident was at risk for complications related to diabetes mellitus type 2, and receiving hemodialysis Monday, Wednesday, and Friday. Under the dialysis section, the care plan indicated R54 had end stage renal disease stage 4, and interventions included no blood pressure in arm with graft (although the resident had a fistula, and the care plan did not direct staff where the access was located), monitor/document/report as needed any signs/symptoms of infection to access site including redness, swelling, warmth, or drainage, Monitor/document/report as needed signs/symptoms of bleeding, hemorrhage, bacterium, and septic shock, check paperwork upon return from dialysis, and chart dialysis weight in Point Click Care (computerized patient record), obtain full set of vital signs, check for bruit/thrills, and monitor for signs of bleeding at	2 830		

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2 830	Continued From page 4 sight. During interview on 7/22/15, at 8:43 a.m. licensed practical nurse (LPN)-A stated she does check R54's access site once per shift, however, she stated she did not document this in the medical record. LPN-A stated dialysis patients get weighed three times per week, however, LPN-A looked in R54's medical record and verified there was only two weights completed for R54 since admission on 7/2/15. During interview on 7/22/15, at 8:52 a.m. R54 stated staff do not look at her access site on her return from dialysis. R54 stated her fistula is covered by gauze and tape when leaving dialysis, and she removes it herself after she returns to the facility. R54 stated staff at the facility have never listened or felt her fistula. When interviewed on 7/22/15, at 8:59 a.m. nursing assistant (NA)-E stated there was nothing special related to obtaining a blood pressure on R54, and there was nothing special related to the residents dialysis treatments she should be aware of. When interviewed on 7/23/15, at 10:07 a.m. LPN-E stated when R54 returns from dialysis she would just ask how she is doing, and weights are completed monthly unless ordered otherwise. LPN-E verified there is no documentation to ensure R54's access site is being monitored. When interviewed on 7/23/15, at 2:21 p.m. registered nurse (RN)-B stated R54 had some, "Missing information" in her medical chart related to the special cares staff needed to provide for a dialysis patient. RN-B verified staff should be obtaining the residents weight and vital signs	2 830		

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2 830	Continued From page 5 daily, and there should be an order and direction to staff to check the access site when R54 returns from dialysis treatment. When interviewed on 7/23/15, at 8:51 a.m. NA-D stated there was nothing special staff needed to know regarding obtaining a blood pressure on R54. NA-D went to check R54's care plan, and stated there was no mention about precautions on taking R54's blood pressure. R54's physician orders from 7/2/15 - 7/23/15, indicated no orders for weights other than monthly per protocol. Review of R54's medication administration record, and treatment administration record, for July 2015, failed to identify an order for special weights or treatment related to pre or post dialysis care or assessment. Review of facility progress notes from R54's record from 7/2/15 - 7/23/15, indicated 7/6/15, 7/8/15, 7/13/15 pre and post dialysis weights were noted, however, there were no other weights from the remaining days of dialysis. Facility policy related to dialysis was requested but none provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs.	2 830		

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2 830	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance with nail care and removal of facial hair for 1 of 2 residents (R14) who were dependent upon staff to maintain grooming. Findings include: R14's diagnosis as noted on the admission record dated 4/14/08, included senile dementia, macular degeneration of the retina, and osteoporosis. R14's quarterly Minimum Data Set (MDS), dated 7/5/15, indicated R14 was rarely/never understood, had long and short term memory problems, required extensive assistance of one staff for transferring, locomotion on and off the unit, dressing, toileting, personal hygiene and bathing, and supervision for eating. R14's plan of care, dated 7/10/15, directed staff	2 920	See POC under F312. Correction Date: 08/31/15.	8/31/15

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2 920	Continued From page 7 to give clear explanation of all care activities prior to and during each contact, and if R14 resists assistance with activities of daily living (ADL), staff were to reassure R14, leave, and return 5-10 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 lip and under the chin. During observation on 7/22/15, at 2:29 p.m., R14 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 long, jagged, and dirty, and the facial hair remained on 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 and their nails were cared for. NA-B stated nail care was usually performed when the residents had a 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 or facial hair shaved, but stated if R14 refused, staff would typically reapproach her and she would allow the cares to be completed at a later time.	2 920		

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2 920	Continued From page 8 During an interview on 7/23/15, at 8:50 a.m., NA-C stated she had given R14 a bed bath on 7/22/15, and verified R14's nail care and hair removal were not completed after giving the bath on 7/22/15, although NA-C could not indicate why. During an interview on 7/23/15, at 9:57 a.m., family member (FM)-A indicated the staff did not consistently provide grooming assistance for R14's nail care and facial hair removal, and stated, "I mentioned it a couple of weeks ago again." FM-A stated she had talked to director of nursing (DON) a few months ago and staff got better about ensuring the cares were complete, however, lately she felt the cares were not being completed. FM-A stated R14 used to pull out the facial hair, adding, "[R14] always took care of that herself. I think the facial hair bothered [R14] when she was still aware of her surroundings." During an interview on 7/23/15, at 10:39 a.m., DON stated staff are instructed to go to the registered nurse or to the unit manager if they are having trouble completing cares for a resident. If a resident refuses cares, staff are trained to wait and go back five minutes later to try again, or to have someone else try. A facility policy for providing grooming services for residents dependent on staff was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could monitor personal cares provided to residents and provide education for staff regarding personal cares. The Director of Nursing or designee could	2 920		

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2 920	Continued From page 9 audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen refrigerators maintained appropriate temperature controls for the safe storage of food items. The facility also failed to ensure required chemical levels for sanitization were maintained for kitchen equipment cleaned using the facility's three-compartment sink. This had the potential to affect all 46 residents who were routinely served meals from the facility kitchen. Findings include: During the initial kitchen tour on 7/20/15, at 2:18 p.m. the facility's meat cooler was observed with the exterior thermometer blinking and a temperature reading of 43 degrees Fahrenheit (F). However, a thermometer located inside the cooler read 46 degrees F. Cook (C)-A stated he was unsure of why the temperature reading was blinking on the cooler's exterior thermometer. Also during the tour, the facility's kitchen was noted as equipped with both a three-compartment	21015	See POC under F371. Correction Date: 08/31/15.	8/31/15

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HERITAGE LIVING CENTER	619 WEST SIXTH STREET PARK RAPIDS, MN 56470

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21015	Continued From page 10	21015		

sink with chemical sanitization, and a dish washer for high temperature sanitization.

During a follow-up kitchen tour on 7/22/15, at 10:59 a.m. the exterior thermometer of the facility's meat cooler was observed as blinking, with a temperature reading of 37 degrees F. The interior thermometer read 40 degrees F. At 11:10 a.m., after C-B and dietary aide (DA)-A opened and closed the cooler several times during meal preparation, the exterior thermometer continued to blink, with a temperature reading of 42 degrees F. The interior thermometer read 45 degrees F. At 11:24 a.m., nearing the end of meal preparation activities, the exterior thermometer continued to blink, with a temperature reading of 45 degrees F and an interior temperature reading of 48 degrees F. The interior thermometer consistently revealed temperature readings of approximately three degrees F above the exterior thermometer. During interview at this time, C-B stated the exterior thermometer typically flashed on and off repeatedly when there was a power outage, but she did not know why it had been blinking for several weeks now. She stated pressing the reset button on the cooler was supposed to resolve the blinking, but each time she tried to reset it, the blinking returned shortly thereafter. C-B confirmed the facility's certified dietary manager (CDM) was aware of these concerns, and she was responsible for review of all temperature logs for the facility's kitchen coolers and freezers.

Also during this follow-up tour, the facility's three-compartment sink was observed filled with various fluids/ solutions, with a dish washing cart holding one plastic cutting board, two Dycem (a manufacturer of non-slip products) mats, and a weaved plastic mat located next to the sink. DA-B

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21015	Continued From page 11 stated most dishes and equipment were run through the dish washer for high temperature sanitization, but added that items such as the plastic mats were solely cleaned using the three-compartment sink because the high temperature dish washer melted the plastic/ Dycem mats. At that time, several weaved plastic mats were observed being used in the dish drying area, placed atop meal trays, with freshly cleaned cups turned upside-down, with the lips of the cups pressed against the mats while the cups were left to air dry. DA-B stated the chemicals for the three-compartment sink were tested routinely and logged, however, DA-B was unable to locate any of the test strips. At 11:30 a.m., DA-C stated she was typically responsible for testing the three-compartment sink solution for the required chemical levels, however, she had been unable to locate any test strips for testing the chemicals since the beginning of the month. She stated the facility's CDM was aware there were no test strips available and stated she believed the CDM had been having a difficult time getting the chemical sanitization company to send test strips to the facility. Review of REFRIGERATOR FREEZER TEMP SHEETS for the facility's meat cooler from 6/17/15, through 7/22/15, temperatures were outside of acceptable ranges for 22 out of 71 (31%) of temperature recording opportunities, including the following: On 6/17/15, the evening shift logged a temperature of 62 degrees F. On 6/19/15, the day shift logged a temperature of 42 degrees F and the evening shift logged a temperature of 43 degrees F. On 6/20/15, the day shift logged a temperature of 42 degrees F.	21015		

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21015	Continued From page 12 On 6/22/15, the day shift logged a temperature of 48 degrees F and the evening shift logged a temperature of 51 degrees F. On 6/23/15, the day shift logged a temperature of 45 degrees F. On 6/27/15, the day shift logged a temperature of 43 degrees F. On 6/28/15, the day shift logged a temperature of 45 degrees F. On 7/2/15, the evening shift logged a temperature of 52 degrees F. On 7/6/15, the day shift logged a temperature of 48 degrees F and the evening shift logged a temperature of 42 degrees F. On 7/7/15, the day shift logged a temperature of 42 degrees F. On 7/8/15, the evening shift logged a temperature of 50 degrees F. On 7/9/15, the evening shift logged a temperature of 42 degrees F. On 7/12/15, the day shift logged a temperature of 42 degrees F and the evening shift logged a temperature of 44 degrees F. On 7/13/15, the evening shift logged a temperature of 42 degrees F. On 7/14/15, the day shift logged a temperature of 48 degrees F. On 7/16/15, the day shift logged a temperature of 42 degrees F. On 7/17/15, the evening shift logged a temperature of 42 degrees F. On 7/18/15, the day shift logged a temperature of 42 degrees F. The logs also lacked readings for an additional 17 of 71 (24%) of opportunities. The temperatures logged did not differentiate whether the interior or exterior thermometer was referenced, however, notations of "flashing" behind most temperatures logged during the day shift, suggested the	21015		

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21015	Continued From page 13 temperatures were read from the exterior thermometer. Review of DISHWASHER TEMP SHEET for the facility's three-compartment sink from 7/1/15, through 7/22/15, identified no test strips were available for 30 of 64 (47%) entry opportunities, with entries lacking for an additional 33 of 64 (52%) entry opportunities. The entry of 400 parts-per million (ppm) on 7/13/15, during the supper meal, was the only test strip result recorded during this time period. During interview on 7/23/15, at 11:29 a.m. the CDM stated staff were to reference the interior thermometer of coolers/ freezers when logging temperature readings, as the exterior thermometers were "not reliable." The CDM stated if a cooler temperature was noted as above 41 degrees F, the staff were to re-check the temperature later in their shift, at a time when the cooler was not being frequently accessed, and if the second temperature reading remained above 41 degrees F, the staff were to report the concern to herself or the facility's maintenance crew. The CDM also stated she reviewed the temperature logs for kitchen coolers about twice weekly, however, she stated she was not aware of any concerns the meat cooler had temperature readings above 41 degrees F. The CDM reported kitchen coolers were to remain at 41 degrees F or below, to ensure safe food storage. CDM stated the following food items were generally stored in the meat cooler: Breakfast meats, bagged/ liquid pasteurized eggs, glasses of juice prepared for upcoming meals, and raw meats thawing for upcoming meals. The CDM acknowledged the facility was low on test strips for a short period of time, but then received some prior to her leaving for vacation the week prior. She was not aware	21015		

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21015	Continued From page 14 C-C had not located test strips for her routine testing of the three-compartment sink. CDM stated the facility's chemical sanitization system was evaluated monthly by Ecolab (the chemical supplier) and she reviewed the DISHWASHER TEMP SHEETS daily. CDM stated C-C typically told her when the kitchen had run out of test strips, but she had not been informed of this to date. The facility's CLEANING OF 3 [three] COMPARTMENT SINKS policy dated 4/1/15, directed chemical sanitizing solutions were to be tested periodically to maintain appropriate levels and to ensure three-compartment sinks were preserved in clean and sanitary condition. SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) or designee could ensure all staff are conducting proper sanitization procedures and provide testing equipment for chemical sanitization to staff. The CDM could monitor the staff to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or	21025		8/31/15

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21025	Continued From page 15 toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain the kitchen refrigerator equipment in good repair. This had the potential to affect all 46 residents who were routinely served meals from the facility kitchen. Findings include: During the initial kitchen tour on 7/20/15, at 2:18 p.m. the facility's meat cooler was observed with the exterior thermometer blinking and a temperature reading of 43 degrees Fahrenheit (F). However, a thermometer located inside the cooler read 46 degrees F. Two medium-sized, metal steam tray containers were observed on top of a plastic meal tray on the top shelf of the cooler, just below the cooler's condensing unit. Both containers were noted with approximately one-half, to one inch of water inside. Cook (C)-A was asked about the purpose of the steam tray pans with water inside, and he stated the containers were placed beneath the condensing unit to capture condensation dripping from the ceiling of the fridge. C-A stated he was unsure of why the temperature reading was blinking on the cooler's exterior thermometer, and stated he was unsure of the kitchens process to fix equipment. C-A stated the facility's certified dietary manager (CDM) was aware condensation had been dripping beneath the condensing unit of the meat cooler, however, nothing had been done to complete any repairs of the cooler. During a follow-up kitchen tour on 7/22/15, at 10:59 a.m. the exterior thermometer of the facility's meat cooler was observed as blinking	21025	See POC under F371 and F456. Correction Date: 08/31/2015.	

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21025	Continued From page 16 with a temperature reading of 37 degrees F. The interior thermometer read 40 degrees F. At 11:10 a.m., after C-B and dietary aide (DA)-A opened and closed the cooler several times during meal preparation, the exterior thermometer continued to blink, with a temperature reading of 42 degrees F. The interior thermometer read 45 degrees F. The two metal steam tray containers remained atop a pink, plastic meal tray on the top shelf of the cooler. The meal tray was noted with a shallow coating of water. The metal containers were observed with greater than two inches of water resting inside. At 11:24 a.m., nearing the end of meal preparation activities, the exterior thermometer continued to blink, with a temperature reading of 45 degrees F and an interior temperature reading of 48 degrees F. The interior thermometer consistently revealed temperature readings of approximately three degrees F above the exterior thermometer. During interview on 7/22/15, at 11:24 a.m. C-B stated the facility's maintenance workers were aware of problems with the meat cooler. C-B stated the exterior thermometer typically flashed on and off repeatedly when there was a power outage, but she did not know why it had been blinking for several weeks now. She stated that pressing the reset button on the cooler was supposed to resolve the blinking, but each time she tried to reset it, the blinking returned shortly thereafter. C-B stated the facility maintenance had replaced a filter in the cooler/ condensing unit approximately two weeks prior, however, the dripping/ condensation continued, along with the blinking thermometer. C-B stated all staff was responsible for completing a maintenance request slip for any kitchen equipment in need of repair. C-B confirmed the facility's CDM was aware of these concerns.	21025		

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21025	Continued From page 17 Review of REFRIGERATOR FREEZER TEMP SHEETS for the facility's meat cooler identified from 6/17/15, through 7/22/15, temperatures were outside of acceptable ranges for 22 out of 71 (31%) of temperature recording opportunities. Logged temperatures which were outside of acceptable ranges for safe food storage ranged from 42 degrees F, to 62 degrees F. During interview on 7/23/15, at 11:29 a.m. the CDM stated if a cooler temperature was noted as above 41 degrees F, the staff were to re-check the temperature later in their shift, at a time when the cooler was not being frequently accessed. If the second temperature reading remained above 41 degrees F, the staff were to report the concern to herself or the facility's maintenance crew. The CDM stated she reviewed the temperature logs for kitchen coolers about twice weekly, however, she stated she was not aware of the concerns the meat cooler had temperature readings above 41 degrees F. The CDM also stated she was not aware of concerns of dripping condensation from the condensing unit in the meat cooler. CDM stated she was aware the dripping of condensation from the ceilings of the kitchen coolers had been a more common occurrence as the coolers had aged, but she was not aware of the current concerns. The CDM was unsure whether facility maintenance was aware of the current condensation concerns in the meat cooler. The CDM reported kitchen coolers were to remain at 41 degrees F or below, to ensure safe food storage. During interview on 7/23/15, at approximately 2:45 p.m. the facility's director of maintenance stated he contacted a refrigeration repair company on 7/22/15, to address the above noted	21025		

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21025	Continued From page 18 concerns with the facility's meat cooler. The company had arrived to repair the cooler on 7/23/15, and indicated the meat cooler had been low on Freon (a gas or liquid used as a refrigerant). A facility policy addressing maintenance of kitchen equipment was requested, but was not provided. 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 CORRECTION: Twenty one (21) days	21025		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi use glucometer (device utilized for monitoring blood sugars) was appropriately disinfected between resident use for 2 of 2 residents (R74 & R29) observed to utilize the community glucometer	21375	See POC under F441. Correction Date: 08/31/15.	8/31/15

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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 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 completely wiped and remain wet for 2 minutes between patient use to ensure appropriate disinfection.	21375		

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21375	Continued From page 20 When interviewed on 7/22/15, at 12:00 p.m. LPN-C stated the community glucometer is to be wiped off with the SuperSaniCloth, however, she was not aware if there was a certain amount of time the glucometer was to remain wet before being used again. When interviewed on 7/22/15, at 12:14 p.m. director of nursing (DON) stated the glucometers are to be cleaned between each use with the purple topped SuperSaniCloth wipes, and the glucometer should remain wet for 2 minutes to ensure disinfection 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could train staff and perform audits to ensure infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and	21426		8/31/15

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21426	Continued From page 21 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility failed to ensure 5 of 5 employees (registered nurse (RN)-A, licensed practical nurse (LPN)-D, nursing assistant (NA)-A, kitchen aide (KA)-A, and activities assistant (A)-A), were adequately screened for tuberculosis (TB), prior to having direct contact with residents. In addition, the facility failed to ensure 1 of 5 residents (R59) had a tuberculosis skin test (TST) read after the second step was completed. Findings include: RN-A's first step TST was administered on 6/9/15. RN-A started with direct resident care on 6/10/15. RN-A's first step TST was read as negative on 6/11/15. RN-A second step TST was administered on 7/21/15, however, the second	21426	It is the policy and procedure of Heritage Living Center to make sure that new staff have a negative Mantoux prior to direect contact with residents and that they receive a two step Mantoux. Staff and residents will have Mantoux read as per state recommendations. 1. Corrective Action: A.)New staff included in the survey had file audits done with TB test repeated as need indicated. B.)Resident chart reviewed. No signs and symptoms of TB. Mantoux (one step) will be repeated. (08/06/15). C.) Policy and Procedure reviewed with nursing staff.	

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21426	Continued From page 22 step TST test result was not read. LPN-D's date of hire was 7/1/15. The first step TST was performed on 1/31/15. LPN-D had no screening for symptoms, nor did the facility re-administer the TST due to it being given over 90 days prior to LPN-D's direct contact with residents. NA-A's date of hire was 3/5/15. NA-A first step TST was administered on 3/12/15, although NA-A started with direct resident contact on 3/6/15, prior to having a TST. NA-A had no date when a second step TST was completed. KA-A's date of hire was 3/5/15. KA-A first step TST was administered on 3/9/15. KA-A did not have a second TST administered. A-A's date of hire was 5/27/15. A-A's first step TST was administered on 5/27/15. A-A had no documentation the first step TST was read, nor was there documentation a second step TST was read. R59's second step TST was administered on 7/23/14, however, R59's medical records lacked a reading of the results for the second TST. During an interview on 7/22/15, at 1:04 p.m., director of nursing (DON) stated When employees come to orientation, they get their first [TST], and then they begin to work with residents. DON stated staff are given notices when they are due for their TST's but stated, "That doesn't always mean they do it." DON stated results are read by RN and LPN staff, but it may not always get recorded where it should be. The facility's policy Tuberculosis Prevention and Control, dated 6/14, indicated the facility must ensure employees, prior to employment and volunteers prior to volunteering, show freedom from active TB, and all employees and volunteers of the facility will be tested prior to employment. In addition, the policy indicated written documentation (including the dates and results)	21426	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 to ensure on going compliance. 3. Re-occurrance will be prevented by: A.) QA audits and staff reminders on an on going basis. B.) Will cover the need to have Masntoux read and two step completed in a timely manner. 4. POC will be monitored by: DON, Dietary Supervisor, Department Heads, Administrator. 5. Correction date: 08/31/15.	

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	00288	A. BUILDING: _____ B. WING _____	07/23/2015

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21426	Continued From page 23 of all pertinent TB testing and evaluation will be easily accessible in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the assessment process for employees and residents to be sure the documentation of the TST are completed. The administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN 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	21620	See POC for F 431 Correction Date: 08/31/15.	8/31/15

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21620	Continued From page 24 patch prior to applying 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. 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.	21620		

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21620	Continued From page 25 When interviewed on 7/23/14, at 10:44 a.m. LPN-C stated when destroying an old Fentanyl patch it is witnessed by two nurses, however, LPN-C was unsure where the second nurse would document this was completed. When interviewed on 7/23/15, at 11:45 a.m. director of nursing (DON) stated the used Fentanyl patch should be cut into small pieces and disposed of in the sharps container, which is required to be witnessed by a second nurse. The DON stated the facility had no documentation to verify a second nurse is witnessing the destruction of the Fentanyl patch due to a computer system issue, however, she stated the corporate office was currently working on a solution. The facility policy titled Duragesic Patches dated 12/31/14, indicated when a patch is removed from a resident the staff is to dispose of the old patch via the Black Hazardous Waste Container in the presence of a witness. The patch will be cut up prior to placement in waste container, and both signatures will be recorded in the resident's medical record. During observation on 7/23/15, at 10:18 a.m. with LPN-E the North back medication cart included one open Lantus (insulin medication used to control diabetes) prefilled pen with a label from the facility medical chart with R54's information on it (name, date of birth), but had no pharmacy label. There was no date on the pen when it was opened, or when it would expire. LPN-E stated she believed the pen may have come with R54 from the hospital.	21620		

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21620	Continued From page 26 On 7/23/15, at 10:29 a.m. observation of the north medication room with LPN-E included one Lantus prefilled pen, unopened, in the refrigerator in an opened box. The pen had a label from R54's medical chart with R54's information on it, but no pharmacy label. On 7/23/15, at 10:44 a.m. LPN-C stated if an insulin pen was received with no label on it, she would use a resident label from the facility chart. On 7/23/15, at 10:53 a.m. observation of the north front cart with LPN-B included a Novolog (insulin medication used to control diabetes) vial for R8 with a pharmacy label on. Despite the vial being opened, no date was noted as to when it was opened, or when it would expire. During interview on 7/23/15, at 11:04 a.m. DON stated insulin should be dated when opened. DON also stated insulin that comes with residents from the hospital staff had been instructed to use a label from the facility chart and put the date opened on the pen/ vial. The facility policy titled Multi Dose Vials revision dated 6/2011, did not address insulin pens or vials. SUGGESTED METHOD OF CORRECTION: The Director of nursing could review and revise policies and procedures to ensure medications are dated when opened and labeled according to standards of practice and on secure destruction of medication. The Director of Nursing could educate nursing staff. The Director of Nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21620		

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